

~~M~~
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18646

CERTIFICATE OF DEATH

(1846)

Reg. Dist. No. 212

1. PLACE OF DEATH:

County

Montgomery
Bethesda, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

32 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

32 days

3. (a) FULL NAME

William H. Abbott

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 19, 1860

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

84

11

16

hrs. min.

9. Birthplace

Waukegan, Illinois

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Martin Abbott

13. Birthplace

Washington, Massachusetts

14. Maiden name

Ellen M. Remond

15. Birthplace

Hobroy, Connecticut

16. Informant

Hospital records

Address

8000 Old Georgetown Rd Bethesda

Date thereof 12/5/45 (month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Burial

Cemetery or crematory

Location

St. J. H. Blue C.

18. Funeral director

Address

901 19th Street

19. 2/5 1945 (Date issued by registrar)

Wm E. Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

DC

County

City or town

Washington

Street No.

6752 McIntire Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 5

1945

at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 2, 1945, to Feb. 5, 1945

and that I last saw him alive on

19

Immediate cause of death

Intestinal

Obstruction

Due to

Volvulus

Accidental fall on ice, January 2nd, 1945.

Due to

Fibrous Adhesive Bands

near 6752 MacArthur Boulevard, Washington, D.C.

Other conditions

Firmular

Pneumonia

Broken leg, right

Major findings of operations

Date of op.

Autopsy results

See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of January 2nd, 1945

Where did injury occur

Washington

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Public place

Means of injury

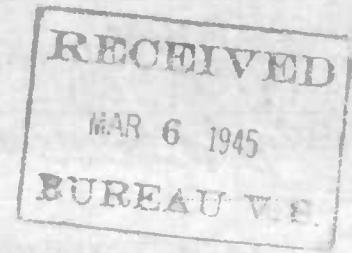
Fall, etc.

Injured at work?

23. SIGNATURE

Richard S. Elbo, M.D.

Address 1834 Eye St. N.W. Date signed 2-5-45



PLEASE WRITE PLAINLY, WITH UNFADED INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

61847

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County *Bethesda, Maryland*City or town *Bethesda, Maryland*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *two days*

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *two days*

3. (a) FULL NAME

*Jesse Franklin Adams*4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*8. (b) Name of husband or wife *Jettie Lee*7. Birth date of deceased (mo., day, yr.) *January 19, 1870*8. (c) If alive, give age *54* years8. AGE: Years *74* Months Days If less than one day hrs. min.9. Birthplace *Elton N.C.*
(Town, county, and state)10. Usual occupation *Styler or Merchant*

11. Industry or business

FATHER 12. Name *Andereson Henry C. Adams*13. Birthplace *North Carolina*MOTHER 14. Maiden name *Andereson Della Cook*15. Birthplace *North Carolina*16. Informant *Danielle Virginia Wife*Address *5614 Roosevelt St.*17. Disposition Date thereof *2/12/45*
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory *Danielle, Virginia*Location *Virginia*18. Funeral director *Leon Benjamin Thompson*Address *7557 Wisconsin Ave. Bethesda, Md.*19. Date rec'd by registrar *2/12 1945* *HHS & Jones*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Montgomery*City or town *Bethesda*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *5614*

Roosevelt ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *FEB. 11TH* 1945 at 100 AM

21. I CERTIFY the death occurred on the date above stated; that deceased from

January 19, 1945, to February 19, 1945

and that I last saw him alive on February 19, 1945

Immediate cause of death

*Arteriosclerotic Heart Disease*Due to *Arteriosclerotic Heart Disease*

DURATION

27 days

5 yrs

Due to *Paralysis due to cerebral hemorrhage*Other conditions *Paralysis due to cerebral hemorrhage*

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Bob Benjamin, M.D.* M. D. or otherAddress *Bethesda, Md.* Date signed *2/14/45*

RECEIVED
MAR 6 1945
BUREAU V.S.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01848

1. PLACE OF DEATH

County

Montgomery

Village or City

Takoma Park Md

Length of residence in city or town where death occurred

yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Charles Anderson Sr.

If U. S. Veteran, specify WAR

(a) Residence: No. 305 Greenwood Ave

(Usual place of abode)

Takoma Park Md

Registration Dist. No. 223

St.

Ward

No. 305-Greenwood Ave

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

MARGARET M. ANDERSON

6. DATE OF BIRTH (month, day, end year)

Oct. 11, 1870

7. AGE

Years

74

Months

3

Days

28

If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. INSPECTOR - RETIRED

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. U.S. G.M.C.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)
(State or country)

BOSTON, MASS.

MOTHER FATHER

13. NAME

GEORGE ANDERSON

14. BIRTHPLACE (city or town)
(State or country)COUNTY CORK
IRELAND.

15. MAIDEN NAME

KATHERINE O'CONNOR

16. BIRTHPLACE (city or town)
(State or country)COUNTY CORK
IRELAND.

17. INFORMANT

(Address) 305 Berlin St. Stone Park Md.

18. BURIAL, CREMATION, OR REMOVAL

Place FOREST GLEN, Md. Date FEB. 10, 1945

19. UNDERTAKER

(Address) 35 Carroll St. phone Park 7-26

20. FILED

Feb. 8, 1945 Attn. DODD

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February 8

(Month) (Day) (Year)

22. I HEREBY CERTIFY. That I attended deceased from

Jan.

1941, to

Feb. 7

1945

I last saw him alive on February 7, 1945; death is said to have occurred on the date stated above, at 12:45 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

1. Terminal Bronchitis
Pneumonia & pulmonary
Congestion

2. Cardiac - vascular neural
disease

Date of onset

2/5/45

1-6-41

Other Contributory Causes of importance:

3. Hypertension (Poor History)

4. Atherosclerosis

1933

1933

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Charles L. Highfield

M. O.

(Address) 717 Clarch Ave N.W. Wash 12. D.C.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	RECEIVED	1 week ago
Run over by street car	MAR 6 1928	1 week ago
Peritonitis		3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

✓
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1952

01849

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County... Montgomery
 City or town... Olney, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution? 3 days

3. (a) FULL NAME

Lena Anderson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Col.

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 1, 1870 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
24 4 10 hrs. min.9. Birthplace... Highland, Howard Co., Maryland
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name John Johnson

13. Birthplace

14. Maiden name... Butler

15. Birthplace... Howard Co., Maryland

16. Informant... Hospital records

Address

17. Burial Date thereof Feb 16, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Spencerville Cemetery

Location... Spencerville, Md.

18. Funeral director... Robert L. Brandon

Address... 246 N. Wash St. Rockville, Md.

19. (Date rec'd by registrar) 2-13-1945 Gent and B. Lawler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Spencerville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6, 1945, to Feb 11, 1945

and that I last saw her alive on Feb 11, 1945

Immediate cause of death

General Septicemia

DURATION

4 days

Due to... injury to Bladder
 followed by septicemia

2 wks.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? At Home - Spencerville - Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

Charles Tumpson M. D. *(Signature)*

Address... Sandy Spring, Md. Date signed... 2/12/45

RECEIVED

MAR 19 1945

LIBRARY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1314

01859

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Five years

Hospital, institution, or street address where death occurred:

Tuscarawas Rd.

At Home and

How long in hospital or Institution?

At Home and

3. (a) FULL NAME

William Stickle Ardingier

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife

Annie Amelia Ardingier

7. Birth date of deceased (mo., day, yr.)

October 2 - 1870

(c) If alive, give age

70

years

8. AGE:

Years

Months

Days

If less than one day

74

4

22

— hrs.

—

min.

9. Birthplace

Williamsport, Md.

(Town, county, and state)

10. Usual occupation

Blacksmith

11. Industry or business

Capitol Transit repair.

Mother Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

Mother

Father

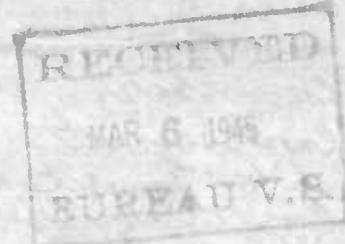
Mother

Father

Mother

Father

Mother



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

01851

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Keep blank if unknown. street address where death occurred:

1917 Rookwood Ave.

How long in hospital or institution?

3. (a) FULL NAME

EVA LEE ATWOOD

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... , widowed

6. (b) Name of husband..... William Milton

7. Birth date of deceased (mo., day, yr.)..... Feb. 28th. 1868 8. (c) If alive, give age..... years

8. AGE: Years..... 76 Months..... 11 Days..... 23 If less than one day..... hrs. min.

9. Birthplace..... Rockville, Md. (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... James Nicholson

13. Birthplace..... Maryland

14. Maiden name..... Caroline Ward

15. Birthplace..... Maryland

16. Informant..... Harold W. Atwood (son)

Address..... 1917 Rookwood Ave. Sil. Spg.

17. Burial..... Burial Date thereof..... Feb - 23 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Marys

Location..... Rockville - Md.

18. Funeral director..... Wayne G. Pumphrey

Address..... 843 Ga Ave. Silver Spring, Md.

19. Date rec'd by registrar..... Feb. 22 1945 Josephine M. Schaeffer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1917 Rookwood Ave.

(If rural, give LOCATION)
none

2.(a) If veteran, name war.....

3. (b) Social Security Number..... none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 21st. 1945 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4th. 1938 19..... to 2/21/45 19..... and that I last saw her alive on Feb. 21st. 1945 19.....

Immediate cause of death

Coronary Occlusion

DURATION

2/20/45

Due to.....

Due to.....

Other conditions..... Coronary Occlusion

Hypertension

(Include pregnancy within 8 months of death)

Major findings or operations.....

none

Date of op.

no autopsy

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

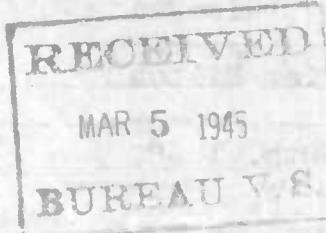
Howard J. Moorehead M. D. or other

Address..... Carrollton Takoma Park Date signed..... 2/21/45

STATION OF THE UNITED STATES MARINE CORPS

RECEIVED MAIL ROOM

EX-1245-307-147-149



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

61852

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... one hour, 45 min.

Hospital, institution, or street address where death occurred:

U.S. Naval Hosp. Bethesda Md -
How long in hospital or institution?... one hour 45 min.

3. (a) FULL NAME

Baby Boy Bailey

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	White	SINGLE

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 2-8-45

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 15 min.

8. Birthplace... U.S. Naval Hospital Bethesda, Montgomery Co.
(Town, county, and state) Maryland

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER	12. Name..... Arthur H. Bailey
---------------	--------------------------------

MOTHER FATHER	13. Birthplace..... Camden New Jersey
---------------	---------------------------------------

MOTHER FATHER	14. Maiden name..... Helen Nelson
---------------	-----------------------------------

MOTHER FATHER	15. Birthplace..... Balaton Minnesota
---------------	---------------------------------------

16. Informant..... Helen N. Bailey

Address..... New Colonial Hotel, Wash. D. C.
--

17. Burial..... Date thereof..... 2-9-45	
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory..... George Washington Memorial

Location..... Hyattsville, Md.

18. Funeral director..... W. W. Chambers
--

Address..... 1400 Chapin St., N.W., Wash., D.C.

19. Date rec'd by registrar..... 7-15-81
--

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia County...

City or town... Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. New Colonial Hotel 15th & M St
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 0800 8 Feb. 19 45 at 8:54 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 0645-8 Feb. 19 45 to 0800 8 Feb. 19 45

and that I last saw him alive on 8 Feb. 19 45

Immediate cause of death.....

Prematurity Infant

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Alan B. Hayles M.D. or other

Address..... Naval Hospital Bethesda, Md. Date signed..... 2/15/81

MEMORANDUM FOR THE SECRETARY OF STATE
RECORDED IN THE RECORDS OF THE

CERTIFICATE OF DEATH

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

01853

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

Montgomery County

Silver Spring City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1606 East West Hyway

How long in hospital or institution?

3. (a) FULL NAME

John Robert Barrett

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Mary D.

7. Birth date of deceased (mo., day, yr.)

April 16th. 1856

8. (c) If alive, give age years

8. AGE:

Years
88Months
10Days
2If less than one day
hrs. min.

9. Birthplace

Canada

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Lumber Industry

MOTHER FATHER

12. Name

Robert J. Barrett

13. Birthplace

Ireland

MOTHER

14. Maiden name

Margaret McCue

15. Birthplace

Ireland

16. Informant

Miss Mary Barrett (Daughter)

Address

1606 E&W Highway, Silver Spg.

17. Removal

Date thereof Feb-19-1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location New Orleans, La.

18. Funeral director

Moore & Pumpelly

Address 843 Ga Ave - Silver Spring, Md.

19. Date rec'd by registrar

19. Y.R.

Josephine M. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

City Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1606 Est West Hyway

(If rural, give LOCATION)

none

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 18

1945, si 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 16 1945 to Feb. 18 1945

and that I last saw her alive on Feb. 17 1945

Immediate cause of death

Congestive Heart failure

DURATION

Due to chronic myocarditis

Due to

Other conditions Generalized arterio sclerosis

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

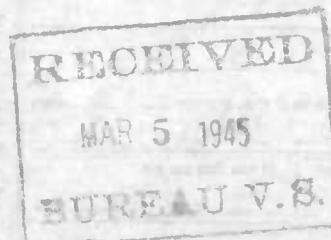
Injured at work?

23. SIGNATURE

M. D. or other

Address Silver Spring, Md. Date signed 2/18/45

HEADS TO THE UNITED STATES MARSHAL
ORIGINALLY ISSUED BY THE
FEDERAL BUREAU OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-04

CERTIFICATE OF DEATH

61854

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Pearl Lattin Beebe

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

B.(b) Name of husband or wife Lawrence S. Beebe

7. Birth date of deceased (mo., day, yr.) Feb 11 1884 6.(c) If alive, give age years

8. AGE: Years 60 Months 11 Days 27 It less than one day hrs. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Carmi Lattin

13. Birthplace N.Y.

MOTHER 14. Maiden name Mary C. Thompson

15. Birthplace N.Y.

16. Informant Lawrence Beebe

Address 7 Broadway St. Chevy Chase

17. Removal Date thereof 2-8-45 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington D.C.

Location Glou W. Wash Co. Inc.

18. Funeral director Geo W. W. Co. Inc.

Address 2900 M st n.W.

19. Date rec'd by registrar 2/8/45, Wm E. Jones Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD

County..... Monty

City or town..... Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7

Roosevelt

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1945, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med Exam. care 19 to 19

and that I last saw h. alive on 19

Immediate cause of death

Acute myocarditis

Due to

Carcinoma of intestinal tract & stomach

Due to

DURATION

2 hrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brochart M.D.

D.P.M. Reg. No. 1945 M. D. or other

Address 61854 Date signed 2-8-45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH ~~INK~~ ADDING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92D

CERTIFICATE OF DEATH

01855

Reg. Dist. No.

318

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery
Rural P.D. Derwood and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

All day

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Elizabeth Ann Blowers

4. Sex

5. Color of race

6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife

Andrew J. Blowers

7. Birth date of deceased (mo., day, yr.)

May 2-1850

6.(c) If alive, give age

1

years

8. AGE:

Years Months Days If less than one day

94

9

3

hrs. min.

9. Birthplace

Montgomery

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Home

FATHER

12. Name

Ephraim Bell & either Ogoton

MOTHER

13. Birthplace

Montgomery County

14. Maiden name

Lydia Cotton Calumet

15. Birthplace

Montgomery County MD

16. Informant

Mrs. Adelie Coglin

Address

Derwood MD

17. Burial

Date thereof - Feb 8-1885

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Laytonsville MD

Location

Montgomery County

18. Funeral director

Roy W. Barber

Address

Laytonsville MD

19. (Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5- 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 3 1945 to Feb 5 1945

and that I last saw her alive on Feb 4 1945

1945

Immediate cause of death

Maternal cardiac disease unknown

DURATION

Due to

Due to

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

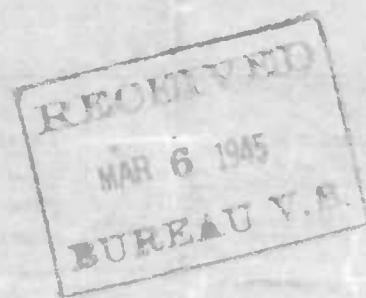
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Vernon H. Ogoton M.D.

M. D. or other

Address Laytonville MD Date signed Feb 8/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 3-34

01856

CERTIFICATE OF DEATH

Reg. Dist. No. 213

FILM NO. G 94 APR 13 1945

1. PLACE OF DEATH:

County... Montgomery

City or town... 326 E. Montg. Ave Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 yrs -

Hospital, institution, or street address where death occurred: 326 E. Montg. Ave

How long in hospital or institution?

3. (a) FULL NAME

Eulalie L.

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 24, 1862

6.(c) If alive, give age..... years

8. AGE:

Years 83

Months 82

Days 2

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Wm Veirs, Bowie, Md.

12. Name

MOTHER FATHER

Maryland

13. Birthplace

Maryland

14. Maiden name

Mary Veirs.

15. Birthplace

Maryland.

16. Informant

Albert M. Bowie

Address

Rockville, Md. (Nephew)

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/7/45

(month) (day) (year)

Cemetery or crematory

Rockville Union Cem.

Location

Rockville, Md.

18. Funeral director

Wm Keeler Humphrey

Address

7557 Wisconsin Ave., Bethesda, Md.

19. Date rec'd by registrar

2/5

1945

Josephine D. Weston

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Rockville, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No... 326 E. Montg. Ave (If rural, give LOCATION)

2.(a) If veteran, name war

Bowie

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 2, 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1943 to Feb. 2, 1945

and that I last saw her alive on Jan 28, 1945

Immediate cause of death

acute cardiac dilatation

Due to: degenerative }
 ability }

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op. —

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

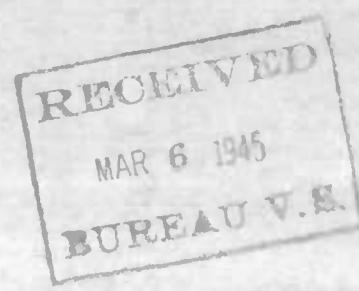
Injured at work?

23. SIGNATURE

M. D. or other

Address

Rockville, Md. Date signed 2/7/45



PLEASE WRITE PLAINLY, WITH UNADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01857

CERTIFICATE OF DEATH

216

Reg. Dist. No.....

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... one month
Hospital, institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution?..... one month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County..... Washington
City or town..... (If outside city or town limits, write RURAL and give nearest town)
Street No. 2116 14th St., S. E.,
(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

BOSWELL, Daniel (n)

3. (b) Social Security Number

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced single
----------------	--------------------------	---

6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.) 13 June 1884

6.(c) If alive, give age..... years

8. AGE: Years 60	Months 9	Days 5	If less than one day hrs. min.
---------------------	-------------	-----------	--

9. Birthplace..... Maryland

(Town, county, and state)

10. Usual occupation..... Retired Navy Man

11. Industry or business

MOTHER FATHER	12. Name..... Joseph J. Boswell
---------------	---------------------------------

MOTHER FATHER	13. Birthplace..... Pr. Geo. Co., Md.
---------------	---------------------------------------

MOTHER	14. Maiden name..... Ann V. Adams
--------	-----------------------------------

MOTHER	15. Birthplace..... Pr. Geo. Co., Md.
--------	---------------------------------------

16. Informant..... Nephew: Mr. Sydney H. Boswell

Address 2116 14th St., S.E., Wash., D.C.

17. burial
(Burial, cremation, or removal. Which?) Date thereof..... 2-21-45

Cemetery or crematory..... Arlington National Cemetery

Location..... Arlington, Va.

18. Funeral director..... Thomas F. Murray

Address 2007 Nichols Avenue, S. E., Wash., D.C.

19. 19 Feb. 1945 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 18 Feb.

19. 45 at 3:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
17 Jan 1945 to 18 Feb. 1945

and that I last saw h. alive on 17 Feb. 1945

Immediate cause of death..... congestive
Heart failure.Due to..... arteriosclerotic heart
disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

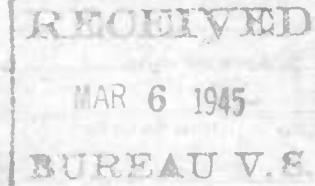
Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Charles W. Thompson M.D.

M. D. or other

Address U.S. N.H., Bethesda, Md. Date signed 2-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for adding of age of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-2-6

01858

Film No. G 94 APR 13 1945

Reg. Dist. No. 223-

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County..... Montgomery

City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
811 Houston Ave.

How long in hospital or institution?

3. (a) FULL NAME

Miss Nancy Brewer

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.) Nov. 27, 1871
..... If alive, give age 73 years

8. AGE:	Years	Months	Days	If less than one day
	73			hrs. min.

9. Birthplace..... Wheeler, New York
(Town, county, and state)

10. Usual occupation..... Bindery Worker

11. Industry or business..... Publishing

12. Name.....	Thomas J. Brewer
13. Birthplace.....	New York

14. Maiden name.....	Martha Derrick
15. Birthplace.....	New York

16. Informant..... Washington Sanitarium Records

Address..... Takoma Park, Maryland

17. Burial..... Cemetery or crematory..... Date thereof.....
(Burial, cremation, or removal, Which?) Wheeler Center Cemetery Feb. 19, 1945.
(month) (day) (year)

Location..... Wheeler, N.Y.

18. Funeral director..... J. Wheeler Wallace

Address..... 254 Carroll St., Takoma Park, D.C.

19. Date rec'd by registrar..... 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 811 Houston Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 14 1945 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1943 to Feb. 14 1945

and that I last saw her alive on January 3 1945

Immediate cause of death..... Acute Cardiac Failure

Due to..... Coronary Occlusion

Due to..... Arteriosclerotic Heart Disease

Other conditions..... Hypertension

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

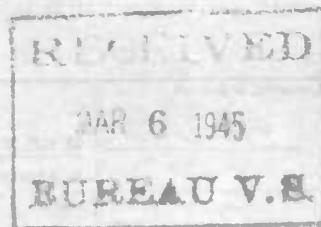
23. SIGNATURE..... M. D. or other

Address..... 45 Carroll Ave., Takoma Pk. Date signed..... 2/14/45

Maryland

RECEIVED CENTRALISATION STATE COUNCIL

RECEIVED BY STAFFED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

01859
618
Reg. Dist. No. 618

1. PLACE OF DEATH:

County

Montgomery
Clarksburg Md R.R. #5

(If outside city or town limits, write RURAL and give nearest town)

City or town

How long in above place of death?

All life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laura V. Brown

4. Sex

Female | Col | Single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

13-August 1927

6. (c) If alive, give age

years

8. AGE:

Years | Months | Days | If less than one day

17

5

22

hrs. min.

9. Birthplace

Montgomery Co. MD

(Town, county and state)

10. Usual occupation

Student

11. Industry or business

School

12. Name

Albert Butter

13. Birthplace

Montgomery County

14. Maiden name

Ethel May Brown

15. Birthplace

Montgomery Co. MD

16. Informant

William Brown

Address

Clarksburg Md

17. Burial

(Burial, cremation, or removal, which?) Date thereof

Feb 11-1945
(month) (day) (year)

Cemetery or crematory

John Wesley

Location

Clarksburg Md

18. Funeral director

Roy W. Barber

Address

Montgomery Co.

19. (Date rec'd by registrar)

1945

h. D. Kelly

Dept.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Clarksburg Md R.R. #5

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 8

1945 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6 1945 to Feb 8 1945

and that I last saw h. a. alive on Feb 8 1945

Immediate cause of death

Solar Pneumonia

DURATION

Due to

Due to

Other conditions

Voluntar. resusc. of heart

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

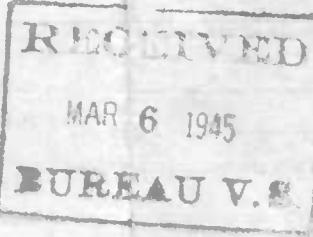
Injured at work?

23. SIGNATURE

R. M. Barber M. D. or other

Address

Montgomery Co. Date signed Feb 10, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01869

Reg. Dist. No. 218

1. PLACE OF DEATH:

County

City or town

Montgomery

P.E.D. Brookville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

fifty years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Malinda E. Brown

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widowed

8.(b) Name of husband or wife

Collens Bowie Brown

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860 Feb 23.

8. AGE: Years Months Days If less than one day
85 0 0 hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

12. Name William Dwyer

13. Birthplace Montgomery Co MD

14. Maiden name Sarah Jane Coombs

15. Birthplace Montgomery Co MD

16. Informant Mrs Bertha V. Brown

Address Brookville Md

17. Burial Date thereof Feb 26 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Montgomery Co MD

18. Funeral director Roy W. Barber

Address Rockville Md

19. Date recd by registrar 3/26/45

(Date recd by registrar) 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Montgomery

County

P.E.D. Brookville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23 - 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 - 1945 to Feb 27, 1945
and that I last saw her alive on Feb 23 - 1945

Immediate cause of death

Coronary occlusion 15 hrs DURATION

Due to Chronic myocarditis

with hypertension

Due to 2 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas. Dumbleson M. D. *Dr. C. Dumbleson*

Address Sandy Spring Md Date signed 3/23/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

01861

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 7 days

3. (a) FULL NAME

Katherine Y. Buhrman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Femalewhitewidowed

6. (b) Name of husband or wife

Alfred G. Buhrman

deceased

7. Birth date of deceased (mo., day, yr.)

Nov. 3, 1881

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

63

3

9

hrs.

min.

9. Birthplace

washington, District of Columbia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name John Young13. Birthplace Germany14. Maiden name Lavina Young15. Birthplace New York16. Informant Barbara B. BuhrmanAddress 1001 Crawford Dr Rockville,
BurialDate thereof 2/13/45
(Burial, cremation, or removal. Which?)

Month (day) (year)

Cemetery or crematory Glenwood Cem.Location Washington, D.C.18. Funeral director Wm. Geddes GeomphreyAddress 7557 Wisconsin Ave. Bethesda, Md.19. 2/13 1945
(Date rec'd by registrar)21-5 Jobes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1001 Crawford

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/12/45 to 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2 - 1945 to Feb 12, 1945and that I last saw her alive on Feb. 12, 1945

Immediate cause of death

Cerebral hemorrhage.

DURATION

10 daysDue to Chronic Cardiac vasculardisease (Hypertension)

3 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address E.G. Bauensfeld, M.D.

M. D. or other

Date signed 2/14/45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 190

01862

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Oak Grove, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General HospitalHow long in hospital or institution? 9 days

3. (a) FULL NAME

John W. Campbell4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Annie Campbell7. Birth date of deceased (mo., day, yr.) July 4, 18738. AGE: Years 71 Months 7 Days 17 If less than one day hrs. min.9. Birthplace Montgomery Co., Md.
(Town, county, and state)10. Usual occupation Habour11. Industry or business Farm12. Name John H. Campbell

13. Birthplace

14. Maiden name Henrietta Brainer

15. Birthplace

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 24, 1945
(month) (day) (year)

Cemetery or crematory

Oak Grove

Location

Montgomery18. Funeral director Bob W. Barber

Address

Lafayetteville19. Feb. 23, 1945 Entombed B. Lawler
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 - Emory Grove

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1945 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 12, 1945 to Feb. 21, 1945and that I last saw him alive on Feb. 21, 1945

Immediate cause of death

Cerebral myocarditis
& extreme nephritis

DURATION

entwoon

Due to

Due to

Other conditions Froze feet2 weeks

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Charles Dunkerson
M. D. or
 Address Sandy Spring, Md. Date signed 2/21/45

RECEIVED
MAR 19 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

(1863)

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH:

County *Montgomery*City or town *Silver Spring*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Arthur Carlton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Oct 10 1897*

8. (c) If alive, give age years

8. AGE: Years *47* Months *4* Days *10* If less than one day hrs. min.9. Birthplace *No Hampshire (Aconia)*
(Town, county, and state)10. Usual occupation *Retired army sergeant*11. Industry or business *Franklin*12. Name *Franklin*13. Birthplace *Franklin*14. Maiden name *Franklin*15. Birthplace *Franklin*16. Informant *Jos. A. Bennett*Address *2026 Laurel St Silver Spring*17. Burial (Burial, cremation, or removal. Where?) *Wash. D. C. Arlington National Cemetery*Date thereof *2-20-50* (month) (day) (year)Location *Arlington, Va.*18. Funeral director *Mr. L. J. Sablesky*Address *4247 - 9th St. NW*19. Date rec'd by registrar *Feb. 30* 1945 *Josephine M. Schaeffer*

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Montgomery*City or town *Silver Spring*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *2026 Laurel St*

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 20 1945 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med. Examiner cause *19 to 19*
and that I last saw h. alive on

Immediate cause of death

coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

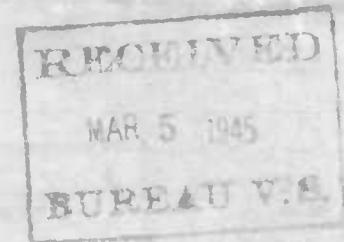
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschart M.D. *Dep Med. Examiner M. D. or other*Address *Washington, Md.* Date signed *2-20-50*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

4515 Gladysne Dr.

How long in hospital or institution?

3. (a) FULL NAME

Pearl W. Corriss

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white marriedB.(b) Name of husband or wife Henry H. Corriss7. Birth date of deceased (mo., day, yr.) July 24 1913

6.(c) If alive, give age years

8. AGE: Years 31 Months 5 Days 13 If less than one dayhrs. min. 9. Birthplace Gaithersburg Md

(Town, county, and state)

10. Usual occupation governor's clerk

11. Industry or business

12. Name Jack Walker13. Birthplace Md14. Maiden name Barbara C. Holland15. Birthplace Md16. Informant Barbara WalkerAddress Gaithersburg Md17. Cremation Date thereof Jan 24 1946(Burial, cremation, or removal. Which?) (month) (day) (year)

Forest Oak Cedar Hill Cemetery

Cemetery or crematory

Location Maryland Gaithersburg18. Funeral director Wm Reuben HumphreyAddress 7557 Wisconsin Ave. Bethesda Md19. 1/23 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4515 Gladysne Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH About Feb 12 1946 at Maryland, M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med Exam care 19... to 19...

and that I last saw h.....alive on

Immediate cause of death aspiration DURATIONHead found 2-27-46 in woodsnear Brandywine Va. decapitatedDue to by passing thru body of 45cerebral V. lutea(Homicide)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of About 1946Where did injury occur? Bethesda (City or town) Maryland (County) Md (State)Injured at home, farm, industry, public place (where?) home

Means of Injury

Injured at work?

23. SIGNATURE Frank J. Brochart M.D. M. D. or otherAddress Gaithersburg Md Date signed 1-22-46

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

01864

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

13 hrs

44 min

Hospital, institution, or street address where death occurred:

Bethesda 14, Maryland

How long in hospital or institution?.....

Same

3. (a) FULL NAME

Infant Boy Caruso

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

—

B. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

February 16, 1945

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

13 hrs. 44 min.

9. Birthplace.....

Bethesda, Maryland

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER

FATHER

12. Name..... Ralph Henry Caruso

13. Birthplace..... Jeanette, Pennsylvania

14. Maiden name..... Martha Elizabeth Stay

15. Birthplace..... Danville, Virginia

16. Informant..... (Mother) Mrs. Ralph H. Caruso

Address..... 4901 Rugby Ave., Bethesda, Md

17. Burial..... Date thereof.....

(month) (day) (year) 2/19/45

(Burial, cremation, or removal. Which?) Cemetery or crematory.....

Location..... Rockville Union

Rockville, Maryland

18. Funeral director..... Wm. G. Johnson, Dempsey

Address..... Bethesda, Maryland

19. (Date rec'd by registrar) 2/18 19. 45

Registrars

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

2/17

19. 45

at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/16

19. 45

to 2/17

19. 45

and that I last saw him alive on 2/16 19. 45

19. 45

19. 45

Immediate cause of death.....

Prematurity - Cerebral Palsy

DURATION

13 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Dr. F. Benjamin, M.D.

M. D. or other

Address..... Bethesda, Md

Date signed 2/19/45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01865

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

407 Brewster Ave

How long in hospital or institution?

3. (a) FULL NAME

Jane Childe

4. Sex

Fe

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William Childe

7. Birth date of deceased (mo., day, yr.)

Feby 28, 1866

8. (c) If alive, give age years

8. AGE:

Years
78Months
11

Days

If less than one day

hrs.

min.

9. Birthplace

Co. Kildare Ireland

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

Mr. Kavanagh

FATHER

12. Name

Ireland

MOTHER

13. Birthplace

Jane Kavanagh

14. Maiden name

Ireland

15. Birthplace

Williams Childe

16. Informant

407 Brewster ave

Address

17. Burial

Date thereof Feb. 8, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or columbarium

Mt. Olivet

Location

Wesley St. & Dr.

about F. J. Ave

18. Funeral director

Albert J. Ashe

Address 641-H St. N.E.

19. Date rec'd by registrar

Feb. 6, 1945

Josephine M. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County

Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 407 Brewster Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feby 6

1945 at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Janv 29

1945

to Feby 5 1945

and that I last saw her alive on

Feby 4

1945

Immediate cause of death

Bronchopneumonia

DURATION

3 days

Due to

Due to

Other conditions

Acute hypertension

several yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Data of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John N. Andrews M.D.

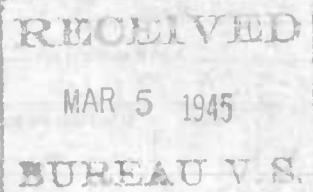
160 Collevalle Rd

M. D. or other

Address

Date signed 2-6-45

Silver Spring Md



③ Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47B

FILM NO. G 94 APR 13 1945

CERTIFICATE OF DEATH

01866

216

Reg. Dist. No.....

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... one month & 18 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... one month & 18 days

3. (a) FULL NAME

CHILDS, John Frank,

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married
----------------	--------------------------	--

8. (b) Name of husband or wife..... Mrs. Ethel N. Childs

7. Birth date of deceased (mo., day, yr.)..... 24 Sept. 1892

8. AGE: Years 52 Months 2 Days 22 If less than one day
..... hrs. min.

9. Birthplace..... Ga. (Town, county, and state)

10. Usual occupation..... Teaching 1921-1944

11. Industry or business..... Pro. Trea. Jr. College Central

12. Name..... Bennie H. Childs

13. Birthplace..... Ga.

14. Maiden name..... Sally E. Nelms

15. Birthplace..... Georgia (deceased)

16. Informant..... wife: Mrs. Ethel N. Childs

Address..... Central, S. C.

17. removal (Burial, cremation, or removal. Which?)..... Date thereof..... 2-17-45
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... W. W. Chambers

Address..... 1400 Chapin St., N.W., Wash., D.C.

19. 17 Feb. 1945

(Date rec'd by registrar) Mary Charlotte Smith

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

S. C.

County.....

City or town..... Central

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 16 Feb. 1945 at 10:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 Dec. 1944 to Feb. 16 1945

and that I last saw him alive on Feb. 16 1945

Immediate cause of death.....

Tumor, mediastinum

Malignant spindlecell carcinoma tumor

Due to cerebral anoxemia

during arrest of heart

Due to after operation for

some minutes. Cardiac massage

Other conditions r.e.v.i.v.ed heart action

but cerebral damage had taken place

(Include pregnancy within 8 months of death)

Major findings of operations Large Anterior mediastinal

tumor

Date of op. 16 Feb. 1945

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

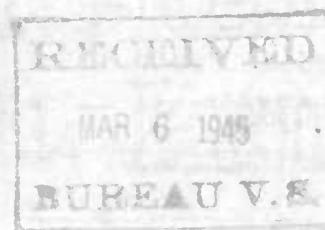
Injured at work?

Edward M. Kent
E. M. KENT, Lt. Comdr. (MC) USNR
M. D. or other

Address..... U.S.N.H., Bethesda, Md. Date signed..... 2-17-45

STAFF TO DEMOCRATIC STATE CHAIRMAN

DEMOCRATIC STATE COMMITTEE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

01867

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2 1/2 hrs.

3. (a) FULL NAME

Daniel Collins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widower

6. (b) Name of husband or wife

Clara O'Neil

7. Birth date of deceased (mo., day, yr.)

May 5, 1861

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

83

9

18

hrs.

min.

9. Birthplace

Potomac, Md.

(Town, county, and state)

10. Usual occupation

waterman

11. Industry or business

Richard Collins

12. Name

Richard Collins

13. Birthplace

Md.

14. Maiden name

Sarah Houser

15. Birthplace

Md.

16. Informant

Brother Tyler Collins

Address

Potomac, Md.

17. Burial

Date thereof 2/26/45

(month) (day) (year)

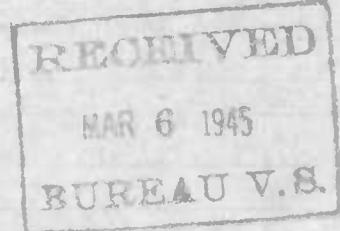
Cemetery or crematory

Potomac Cemetery

Location

Potomac, Md.

(Burial, cremation, or removal. Which?)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

01868

CERTIFICATE OF DEATH

Reg. Dlat. No. 218

1. PLACE OF DEATH:

County Montg. Co.
City or town Clarksbury Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town) 76 yrs

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Eli Garrett Cooley

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Effie Ann Cooley

66

7. Birth date of deceased (mo., day, yr.) Sept 17th 1868
.....(c) If alive, give age years8. AGE: Years Months Days If less than one day
1868 76 4 16 hrs. min.9. Birthplace Clarksburg Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Amos Cooley
Md,

MOTHER 13. Birthplace Elizabeth Mitchell

14. Maiden name Ma,
15. Birthplace16. Informant Effie Ann Cooley
Clarksburg MdAddress Burial 2/6/45
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Clarksburg Cemetery
Location Clarkaburg Md

18. Funeral director Ernest C Gartner

Address Gaithersburg Md,

19. Feb 4 1945 Alinda L Cooley
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Clarksburg Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

Feb 3rd

45

4.35

Am

2D. DATE OF DEATH
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1944 to Feb 2 1945
and that I last saw h. m. alive on Feb 2 1945

Immediate cause of death

Sudden Tachycardia

DURATION

Due to

Due to

Other conditions

Respiratory distress

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

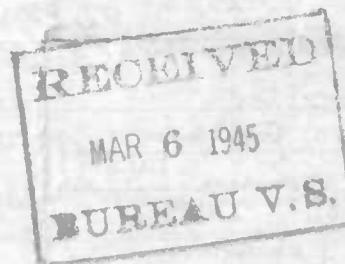
Injured at work?

23. SIGNATURE Mary Stanley M. D. or other

Address Gaithersburg Date signed Feb 3 1945

RECEIVED BY THE LIBRARY OF THE STATE OF ILLINOIS

RECEIVED MAR 6 1945



Evidence for change of age & birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

01869

CERTIFICATE OF DEATH

Reg. Dist. No. 216

FILM NO. G 94 MAY 14 1945

1. PLACE OF DEATH:

County Montg.

City or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

4827 Fairmount Ave.

How long in hospital or institution?

3. (a) FULL NAME

Arthur Dallenger

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married.

6. (b) Name of husband or wife Catherine

7. Birth date of deceased (mo., day, yr.) May 21, 1863 1868

8. AGE: Years Months Days If less than one day
76 7-7- hrs. min.

9. Birthplace England

10. Usual occupation Retired

11. Industry or business

12. Name Benjamin Dallenger

13. Birthplace England

14. Maiden name Lulu Proctor

15. Birthplace unknown

16. Informant Emma Yarrington

Address 4827 Fairmont Ave

17. Burial Date thereof 5/21/45
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory National Memorial Park Cemetery

Location Lee Highway, Va

18. Funeral director Lee Reuben Humphrey

Address 7557 Wisconsin Ave. Bethesda, Md

19. (Date rec'd by registrar) 7/2 1945 Wm E. Jolley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg.

City or town Bethesda, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4827 Fairmount Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 1, 1945, et 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1942 to Jan 31 1945

and that I last saw h. alive on Jan 31 1945

Immediate cause of death

Coronary thrombosis

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 806 Kenyon Rd Date signed 2/2/45

PLEASE WRITE PLAINLY, WITH FINE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGON, D. C.
CERTIFICATE OF DELIVERY

RECEIVED
MAR 6 1945
FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1920

CERTIFICATE OF DEATH

01870
Reg. Dist. No. 213-

1. PLACE OF DEATH:

County Montgomery
City or town Rockville R. 7 D. #7
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Davis

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

male Colored Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 11, 1874 8. (c) If alive, give age years8. AGE: Years 70 Months 5 Days 21 If less than one day9. Birthplace Maryland (Town, county, and state)10. Usual occupation Laborer11. Industry or business Bonner Davis12. Name Bonner Davis13. Birthplace Va.14. Maiden name Rachel Murphy15. Birthplace Howard Co. Md.16. Informant Timothy DavisAddress Rockville, Md.17. Buried Buried Date thereof Feb 5-1945
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory NorbeckLocation Norbeck, Md.18. Funeral director Robert L. GraweAddress 246 N. W. St. Rockville19. Date rec'd by registrar Feb 5 1945 Josephine D. Grawe(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville R. 7 D. #7
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 21945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Examin. case 19 to 19
and that I last saw h. alive on 19

Immediate cause of death

Acute myocarditis
Due to chronic carditis - renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brinham M.D. Dep. Med. Examiner M. D. or otherAddress Gathertown, Md. Date signed 2-3-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

01871

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months and 24 days

Hospital, institution, or street address where death occurred:

U.S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 2 mons. 24 days

3. (a) FULL NAME

DAY, Paul (n), S/c SV USNR

4. Sex male	5. Color or race W-US	6. (a) Single, married, widowed, or divorced married
----------------	--------------------------	---

8. (b) Name of husband or wife Mrs. Rommel Day

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 July 1914

8. AGE: 30	Years Months 7	Days 1	If less than one day hrs. min.
---------------	----------------------	-----------	--------------------------------------

9. Birthplace S.C.
(Town, county, and state)

10. Usual occupation Navy

11. Industry or business Navy

FATHER 12. Name Jacob Day

13. Birthplace S.C.

MOTHER 14. Maiden name Estell Hall

15. Birthplace S.C.

16. Informant Wife: Mrs. Rommel Day

Address 2901 Army Navy Drive, Arlington, Va.

17. removal Date thereof 2-16-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location West Columbia, S.C.

18. Funeral director W.W. Chambers,

Address 1400 Chapin St., N. W., Wash. D. C.

19. 2-16-45 19.....
(Date rec'd by registrar) Mary Charlotte Smith

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County Arlington

City or town Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 Army Navy Drive,

(If rural, give LOCATION)

2.(a) Is veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 15 Feb. 19. 45 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

22 Nov. 19. 44 to 15 Feb. 19. 45

and that I last saw h. im. alive on Feb. 15 19. 45

Immediate cause of death

hobar Pneumonia

DURATION

3 days

Due to Acute Hydrocephalus
encephalitis

4 mo.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

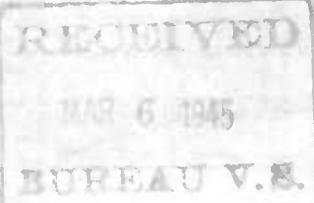
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury L. T. GIBB, Jr. Comdr. (MC) USNR
Injured at work?23. SIGNATURE W. T. GIBB, Jr. Comdr. (MC) USNR
M. D. or other

Address US N.H., Bethesda, Md. Date signed 2-16-45



M

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

01872

FILM G 94 APR 13 1945

Reg. Diat. No. 218

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Montgomery
 County Metroopolitan Zone
 City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME John Henry Plassey Jr.

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Maria P. Plassey

7. Birth date of deceased (mo., day, yr.) December 10, 1867 8. (c) If alive, give age 60 years

8. AGE: Years 78 Months 77 Days If less than one day hrs. min.

9. Birthplace Charles County, Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER 12. Name John Henry Plassey
 13. Birthplace Charles County, Md

MOTHER 14. Maiden name Julia Chase 15. Birthplace Charles County, Md

16. Informant Maria P. Plassey (wife)

Address Metroopolitan Zone, Md.

17. Burial Buried Date thereof Feb 16 1945 (month) (day) (year)

Cemetery or crematory Emery Zone Cemetery

Location Emery Zone, Md.

18. Funeral director Rabert L. Snauder

Address 246 N. Wash. St. Rockville Md.

19. Date rec'd by registrar Feb 14 1945 Address Alvada L. Cook Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Maryland
 City or town Metroopolitan Zone (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 13 1945 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 6 1945 to Dec 12 1945

and that I last saw him alive on Dec 12 1945

Immediate cause of death Bronchopneumonia

DURATION

Due to Pneumonia

Due to

Other conditions valvular lesions of heart

(Include pregnancy within 8 months of death)

Major findings at operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

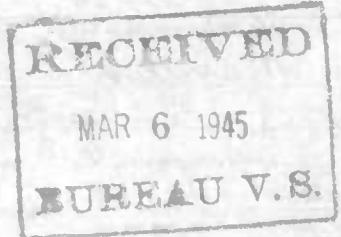
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE Henry Plassey Jr. M. D. or other

Address Emery Zone Date signed Feb 14 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct tag is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-97

CERTIFICATE OF DEATH

01873

Reg. Dist. No. 191-217

1. PLACE OF DEATH:

County

Montgomery

City or town

Brookside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Leonard Dwyer

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

married

6. (b) Name of husband or wife

Wetlie Dwyer

7. Birth date of deceased (mo., day, yr.)

Feb. 4, 1871

years

8. AGE:

Years

Months

Days

If less than one day

74

0

9

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

12. Name

Mrs E Dwyer

13. Birthplace

Md

14. Maiden name

Helena Magrone

15. Birthplace

Md

16. Informant

Mrs G C Dwyer

Address

Glenwood Md

17. Burial

Date thereof 2-16-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Providence

Location

Glenelg Md

18. Funeral director

J.C. Bigumbrotham

Address

Elliot City Md

19. Feb. 16, 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Howard

City or town Glenwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. Knollwood

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 13 - 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 13 - 1945 to Feb 13 - 1945

and that I last saw h. M alive on Feb 13 - 1945

Immediate cause of death

Carcinomatosis of chest

DURATION

unknown

Due to

Carcinoma of throat

20 yrs

Due to

Other conditions no

(Include pregnancy within 3 months of death)

Major findings or operations

no

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

no

Injured at work?

no

23. SIGNATURE

Chas. Umbleton M. D. S.A. 8/14/45

Address

Sandie Young Jr Date signed 8/14/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(126)

1874

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.
 City or town Bethesda - Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 6 days

3. (a) FULL NAME

Mrs) Gertrude Eastman4. Sex F5. Color or race W.6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Frank W. Eastmandeceased

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Oct. 5 - 1862

8. AGE:

Years	Months	Days	If less than one day
82	4	7	hrs. min.

9. Birthplace Arlington - Mass.

(Town, county, and state)

10. Usual occupation D.W.

11. Industry or business

12. Name E. Chapman

FATHER

MOTHER

Maiden name

Birthplace

Location

Name

Field

Mass.

16. Informant Mrs. F. C. Meier - daughterAddress 6402 Beechwood Ave. C.M.D.17. (Burial, cremation, or removal. Which?) ShipmentDate thereof 5/31/45

(month) (day) (year)

Cemetery or crematory Framingham, Mass.Location Framingham, Mass.18. Funeral director Elow Pendleton ThompsonAddress 7557 Wisconsin Ave. Bethesda19. 5/31 1945 Mr. E. John M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Cherry Chase Rd.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6402 Beechwood Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

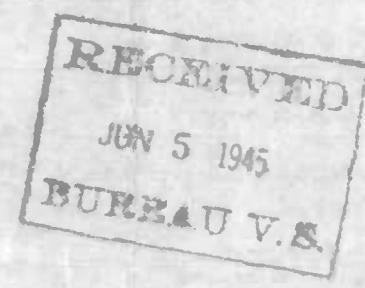
Feb. 11 1945 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 1 1945 to Feb. 11 1945and that I last saw her alive on Feb. 11 1945

Immediate cause of death

BeretonitisGlobethusSeepage from gall bladdergastro-ileal fistulagastro-ileal fistula



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115-1

CERTIFICATE OF DEATH

Reg. Dist. No. 216

01870

~~The~~
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied.
 The
 correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Montgomery
 County Cabin John
 City or town Collier John Goldmark
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:
#25 Erecsson Road
 Stay in hospital or inst. (yrs., or mos., or days)
 Stay in this community (yrs., or mos., or days) 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State _____ County _____
 City or town _____ Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. _____
 (If rural give LOCATION)
 2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Garry James Eaves
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

3. (b) Social Security Number

6 (b) Name of husband or wife (child)

7. Birth date of deceased (mo., day, yr.) October 28-1944.

8. AGE: Years 3 Months 6 Days - If less than one day - hrs. - min.

9. Birthplace #25-Erecsson Rd, Cabin John Goldmark
 (Town, county, and state) Cabin John, Md.

10. Usual occupation Child

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 3rd 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1945, to Feb. 3 1945, and that I last saw him alive on Feb. 2 1945.

Immediate cause of death

Oedema of the glottis.
 Due to Septic sore throat
 Due to exposure

DURATION

a few hours,
2 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

11. Industry or business janitor 12. Name Garry John Eaves
 MOTHER FATHER Frances Hodges
 13. Birthplace Virginia
 14. Maiden name Frances Hodges
 15. Birthplace Virginia

16. Informant Frances Eaves

Address #25-Erecsson Rd, Cabin John Goldmark
 Burial Burial Date thereof Feb. 3, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory National Memorial Park
 Location Falls Church, Va.

18. Funeral director W W Chambers Co
 Address 3072 - 11 st NW

19. 2-3-45 Date rec'd by registrar NE Jabs.
 (Date rec'd by registrar) 19-
 Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

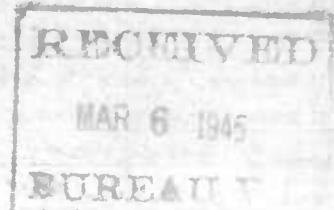
Means of injury _____ Injured at work? _____

23. SIGNATURE

Wheeler Huff, M.D.
 M.D. or other _____
 Address Bethesda, Md. Date signed Feb. 3/45

BUFILE NO. 100-10000000000000000000000000000000

BRANCH 10 - STATION 6000



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

01876

216

Reg. Dist. No.

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
Now long in above place of death? 2½ days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County Washington
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 1628 N. 16th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war. ✓

3. (a) FULL NAME

EDIE, Ann

4. Sex female	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married
---------------	-----------------------	---

6.(b) Name of husband or wife Capt. J. R. Edie USN Ret.

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1884

6.(c) If alive, give age years

8. AGE: Years 61	Months 0	Days 2	If less than one day hrs.	min.
------------------	----------	--------	-----------------------------------	--------------

9. Birthplace Tenn. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant husband: Capt. J. R. Edie, Ret.

Address 1628 16th St., N.W., Wash., D.C.

17. burial Date thereof 2-17-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Joseph Gowler

Address 1750 Penn., Ave., N. W., Wash., D.C.

19. 15 Feb. 45 Mary Charlotte Smith

(Data rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945 at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 12 1945 to Feb. 15 1945

and that I last saw h. 10 alive on Feb. 14 1945

Immediate cause of death General Demarcation

a. Right Hemiplegia

Due to (Reason) and I dyed stroke, Malaria

Due to Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of _____

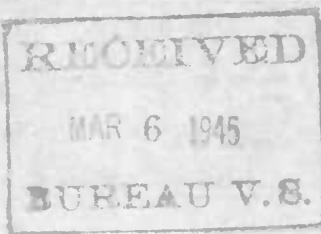
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gordon R. Lamm M. D. or other

Address Natl. War Res. Center Date signed Feb. 15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

01877

CERTIFICATE OF DEATH

Reg. Dlat. No. 214

1. PLACE OF DEATH: Montg Co
 County Silverspring, Md. (Rural)
 City or town. (If outside city or town limits, write RURAL and give nearest town) 1 Yr 2da
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Montg Co.
 City or town Silverspring (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9509 Riley Drive
 (If rural, give LOCATION)

3. (a) FULL NAME

Roberta Garrett Esworthy

3. (b) Social Security Number

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Wid Ow
---------------	------------------------	--

6.(b) Name of husband or wife Frank Esworthy

7. Birth date of deceased (mo., day, yr.) Oct 14th 1859

8. AGE: Years 1859	Months 85	Days 4	If less than one day 0	hrs.	min.
--------------------	-----------	--------	------------------------	-----------	-----------

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation House Wife
 If II

11. Industry or business Samuel Thrift

MOTHER FATHER 12. Name Ellen Hawkins

13. Birthplace Md.

14. Maiden name Md.

15. Birthplace

16. Informant Eva Byrnes

Address Gaithersburg Md.

Burial 2/17/45
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Darnestown Cemetery

Location Darnstow Md.

18. Funeral director Ernest C. Gartner

Address Gaithersburg Md.

19. Feb 14 1945 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 14th 1945 at 12.25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1944 to Feb 14 1945

and that I last saw her alive on Feb 13 1945

Immediate cause of death Congestive

Heart Failure

DURATION

3 days

Due to Cardiac and Renal Disease

10 yrs

Due to Diabetes mellitus

10 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

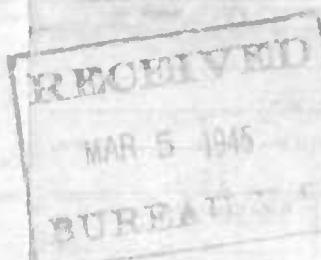
23. SIGNATURE Harold Hedges, M.D.

M. D. or other

Address Mayflower Hotel Date signed 2/14/45

LETTER TO DIRECTOR STATE GRANT

RECEIVED BY TELETYPE



16-1211-6064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Signature)*

01878

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

3 Days

3. (a) FULL NAME

Agnes Evans

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

married

6. (b) Name of husband or wife

William

7. Birth date of deceased (mn. day, yr.)

Sept- 11, 1883

6. (c) If alive, give age years

8. AGE:

Years
61Months
5Days
15

If less than one day

hrs. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Frasier

13. Birthplace

*Virginia**Clark*

14. Maiden name

15. Birthplace

Virginia

16. Informant

self

Address

17. Burial

Burial

cremation, or removal

which

Date thereof
(month) (day) (year)
3-1-45

Cemetery or crematory

Potowmack

Location

*Potowmack, Md.**W² Reuben Gumprey*

18. Funeral director

Address

*Bethesda, Md.**W E Jones*

19. Date rec'd by registrar

3-1-45

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Wilson Lane near River Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb- 26, 1945 at *7:03 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 24, 1945 to *Feb 26, 1945*and that I last saw her alive on *Feb 26, 1945*.

Immediate cause of death

acute toxic hepatitis
peritonitis & mesenteric

Due to

Thrombocytopenia
protective attitude

Due to

Spasmodic Hernia

Other conditions

Pulmonary congestion

20 yrs.

(Include pregnancy within 8 months of death)

Major findings or operations

I resected Hernia
liver

Date of op.

Autopsy results

C.P.C. Large mesentery & liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

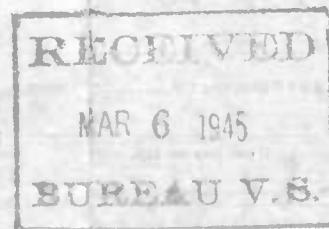
Means of injury Injured at work?

23. SIGNATURE

Lawry Organ, M.D.

M. D. or other

Address *1801 Eye St NW DC* Date signed *3-1-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52D

01879

CERTIFICATE OF DEATH X

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Maryland Sanitarium and HospitalHow long in hospital or institution? 17 days

3. (a) FULL NAME

Margaret Frederick

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife William Arthur Frederick

7. Birth date of deceased (mo., day, yr.)

July 12 1884

8. (c) If alive, give age

62 years

8. AGE:

Years 60 Months 7 Days 12 If less than one day
hrs. _____ min. _____

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home12. Name Michael Michael13. Birthplace Ireland14. Maiden name Mary Harvey15. Birthplace Ireland16. Informant Admission record on chart

Address

17. (Burial, cremation, or removal. Which?) Cremation Date thereof Dec 1945 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director The S. H. Flores Co.
Address 2901-14 - st N.W. Wash. D.C.19. 2/25/45 (Date rec'd by registrar) J.W. Murphy (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. D.C. County _____

City or town _____ (If outside city or town limits, write RURAL and give nearest town)

Street No. 1206 Kennedy St.

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 8 1945 to Feb. 24 1945and that I last saw her alive on Feb. 23 1945

Immediate cause of death

Carcinoma of Bladder
with Metastasis to
surrounding tissues

DURATION

5 years

Due to

Other conditions

Polyuria -

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

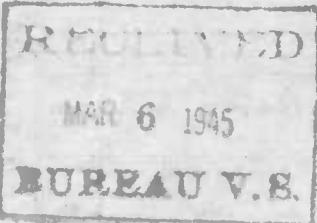
Means of injury

Injured at work?

23. SIGNATURE John H. Brown Jr. M.D.

M. D. or other

Address Tolson's Park Date signed 2/25/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

01889

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MontgomeryCity or town Redland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

Redland, Md.

How long in hospital or institution? _____

3. (a) FULL NAME

Henrietta Gardiner

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Single

6. (b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.)

July 3, 1861

B. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Frederick Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

William Gardiner

12. Name

William Gardiner

13. Birthplace

Unknown

14. Maiden name

Ann Green

15. Birthplace

Hartford Co. Md.

16. Informant

Melvin S. Penn

Address

Stephew, Redland, Md.

17. (Burial, cremation, or removal. Which?)

Burial Date thereof 2/8/45
(month) (day) (year)

Cemetery or crematory

St. Rose Cemetery

Location

Maryland

18. Funeral director

Lew Pearson Humphrey

Address

Rockville, Md.

19. (Date rec'd by registrar)

2/6/45 19. Josephine D. Foote

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty MontgomeryCity or town Redland, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Redland, Md.

(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 5 1945 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Stephew, even case to 10
and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

DURATION

dead

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brochart M.D.Def Med. Exay

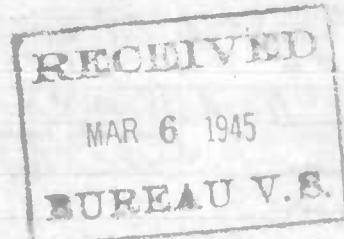
M. D. or other

Address

Washington, D.C. Date signed 2-5-45

LETTERS TO THE UNITED STATES GOVERNMENT

REGARDING THE
PROBLEMS OF THE JAPANESE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

Evidence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

01881

CERTIFICATE OF DEATH

Reg. Dist. No. 214

FILM C 94 MAY 11 1945

1. PLACE OF DEATH:

County Montgomery Co.
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 2 mos.

3. (a) FULL NAME

(Mrs) Evelyn L. Gooding

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Charles B. Gooding

7. Birth date of deceased (mo., day, yr.)

Oct - 10 - 1888 - 3 1882

6.(c) If alive, give age years

8. AGE:

Years 62

Months 4

Days 8

If less than one day

hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation

PA. U.

11. Industry or business

MOTHER FATHER	12. Name	Joseph E. Leslie
	13. Birthplace	Richmond, Va.

MOTHER	14. Maiden name	Josephine Padgett
	15. Birthplace	Richmond, Va.

16. Informant	Charles B. Gooding
	Address

17. Burial	41. Dupont Ave. Reservation
	(Burial, cremation, or removal. Which?)

Cemetery or crematory	Glenwood
	Date thereof

Location	Washington, D.C.
	(month) (day) (year)

18. Funeral director	Edward E. Humphrey
	Address

Address	8434 Ga Ave. Silver Spring
	Date rec'd by registrar

19. (Date rec'd by registrar)	Feb. 20 1945
	Josephine M. Schaff

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 41 W. Dupont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 18 1945 at 9:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 30 1945 to Feb. 15 1945
and that I last saw her alive on Feb. 18 1945

Immediate cause of death

Coronary Thrombosis

DURATION

19 days

Due to

Due to

Other conditions Hypertension
Heart Disease

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.
Autopsy results Substantiation of clinical diagnosis
PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

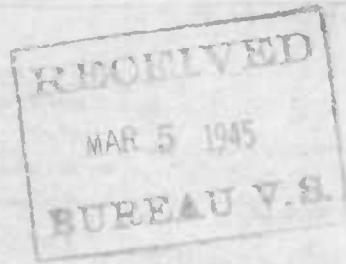
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Garrison Banshead MD
Silver Spring, Md. Date signed 3/18/45
M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2400

01882

216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 17 days
Hospital, Institution, or street address where death occurred:..... U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County.....
City or town..... Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Army and Navy Club
(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

GREEN, Lucien Byron, Lt. Comdr. USN Ret. Inactive

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6 Jan 1889

8. AGE: Years	Months	Days	If less than one day
56	1	20	hrs. min.

9. Birthplace..... Wis.
(Town, county, and state)

10. Usual occupation..... NAVY

11. Industry or business

MOTHER FATHER 12. Name..... Albert E. Green

13. Birthplace..... Wis. (deceased)

14. Maiden name..... Olive Austin

15. Birthplace..... Ill. (deceased)

16. Informant..... son: Sgt. Lucien B. GREEN

Address Box X, Gambou, Canal Zone

17. Burial..... Date thereof..... 2-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Location..... Arlington, Va.

18. Funeral director..... S. H. HINES W. Brown

Address 2901 14th St., N. W., Wash. D.C.

19. Feb. 26 1945 Mary Charlotte Smith
(Date rec'd by registrar) Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2-26 1945 at 015 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 Feb. 1945 to 26 Feb. 1945

and that I last saw him alive on

Immediate cause of death..... Hemorrhage from esophageal varicosities

Due to..... Atrophic Cirrhosis of the liver

Duration.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... Cirrhosis of liver with esophageal varicosities

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert P. M. Tomb, Lieut. m/c USNR

M. D. or other

Address..... US Naval Hospital, Bethesda Date signed..... 2/26/45

THE UNITED STATES GOVERNMENT

CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1863

01883

Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

608 Pickwick Lane

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) 5 years

3. (a) FULL NAME

Anna Augusta Heitmuller

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6 (b) Name of husband or wife Albert Heitmuller

7. Birth date of deceased (mo., day, yr.) 18 September 1859

8. AGE: Years Months Days If less than one day

85 4 16 hrs. min.

9. Birthplace Reusendorf, Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name August Marshalk

13. Birthplace Germany

14. Maiden name Christine ?

15. Birthplace Germany

16. Informant Anita Louise Foster

Address 608 Pickwick Lane

17. Burial, cremation, or removal. Which? Date thereof 2-4-45
(month) (day) (year)

Cemetery or crematory _____

Location _____

18. Funeral director J. A. Hines Co

Address Wash D.C.

19. 2-4-45-19
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 608 Pickwick Lane

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 February 1945 19 at 10 AM

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from

21 June 1943 to 4 February 1945

and that I last saw her alive on 2 February 1945

Immediate cause of death Pulmonary embolism DURATION

Unknown

Due to Fracture, right hip, 3½ mos

27 October 1944.

Due to Accidental fall. Patient slipped and fell in her bedroom. Cured.

Other conditions Arteriosclerosis, Unknown generalized with hypertension.

(Include pregnancy within 8 months of death)

Major findings:

Of operations no

Of autopsy no

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Accident Date of

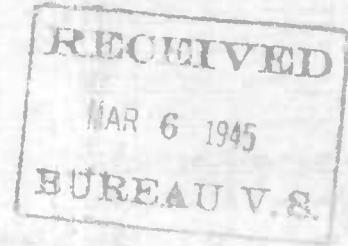
Where did injury occur? Chevy Chase, Montgomery Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Accidental fall, injured at work?

23. SIGNATURE W. L. Nalls

M. D. or other M. C.
Address W. L. Nalls, Lt. Colonel, M. C.
Date signed 5 Feb 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01884

CERTIFICATE OF DEATH

216

Reg. Dist. No.....

1. PLACE OF DEATH:

County.....Montgomery

City or town.....Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....3 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?.....3 days

3. (a) FULL NAME

HENNIGAR, William Everett, Captain USN

3. (b) Social Security Number

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married
----------------	--------------------------	--

6.(b) Name of husband or wife.....Gladys Hennigar

7. Birth date of deceased (mo., day, yr.).....17 May 1901

8. AGE: Years
43 Months
9 Days
18 If less than one day
hrs. min.9. Birthplace.....New York
(Town, county, and state)

10. Usual occupation.....Navy

11. Industry or business

12. Name.....William A. Hennigar

13. Birthplace.....N.Y.

14. Maiden name.....Alice Smith

15. Birthplace.....N.Y.

16. Informant.....wife: Mrs. Gladys Hennigar

Address.....4818 South 30th St., Arlington, Va.

17. burial
(Burial, cremation, or removal. Which?) Date thereof.....22 Feb. 45
(month) (day) (year)

Cemetery or crematory.....Arlington National Cemetery

Location.....Arlington, Va.

18. Funeral director.....W. W. CHAMBERS

Address.....1400 Chapin St., N. W., Wash., D. C.

19. 20 Feb. 1945.....Mary Charlotte Smith
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Va.

County.....Arlington

City or town.....Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No.....4818 South 30th Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....19 Feb.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
16 Feb. 1945, to 19 Feb. 1945,
and that I last saw h. i.m. alive on 19 Feb. 1945.

Immediate cause of death.....

Due to.....Toxoplasma Bacterial
Pneumonia

Due to.....Dystentery Intestinal

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operation.....Dystentery diagnosed
Obstruction Intestinal Date of op. 2-16-45 2-18-45

Autopsy results.....Bilateral Bronchitis Pneumonia Dystentery

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

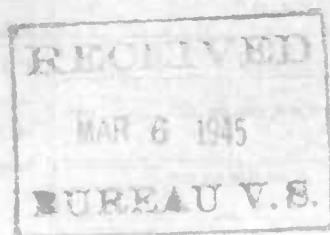
Injured at work?

23. SIGNATURE.....W. Warren Sager, Comdr (Ret.) USNR

M. D. or other

Address.....US NAVAL HOSP., Bethesda, Md. Date signed.....2-20-45

ATTACH TO TRANSMISSION STATE ORIGINATOR
ORIGINATOR'S ADDRESS
ORIGINATOR'S TELETYPE NUMBER
ORIGINATOR'S CALL LETTERS



M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01885

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 35 days

3. (a) FULL NAME

Edward Hill4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1898?8. AGE: Years 46? Months 4 Days 17 It less than one day hrs. min.9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name John Hill13. Birthplace Maryland14. Maiden name Donald15. Birthplace Maryland

16. Informant.....

Address Rewald17. (Burial, cremation, or removal. Which?) Date thereof 2-20-45
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director J. H. LoveAddress 2426 - 1st N.W. D.C.19. 2-20-45 19
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Friendship Heights, Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. River Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 - 1945 19 at 720 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 19. 19.

and that I last saw h. alive on 19. 19. 19.

Immediate cause of death Burns of personAcute MyocarditisSore throat (left upper)Breath Acute PericarditisEsophagitisDue to 1st 2nd & 3rd degreeburns of both lower extremitiesOther conditions thicks of upper

(Include pregnancy within 3 months of death)

Major findings of operations.....

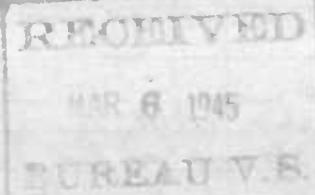
Date of op.

Autopsy results 1st 2nd, 3rd degree burn of upper

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Jan 15-1945Where did injury occur? Glenmore (4901 Newport Ave) Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) IndustryMeans of injury Burns Injured at work? Yes23. SIGNATURE J. H. Love M. D. or other PhysiologistAddress Somney 8227 7th St. Date signed 2/19/45



PLEASE WRITE PLAINLY, WITH
INK. Supply every item of information carefully.
Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01886

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7611 Eastern Avenue

How long in hospital or institution?

3. (a) FULL NAME

Ruby S. Howell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White married

6. (b) Name of husband or wife

Henry C. Howell

7. Birth date of deceased (mo., day, yr.)

Sept. 8, 1889

6. (c) If alive, give age

years

8. AGE:

Years	Months	Days	If less than one day
55	5	0	hrs. min.

9. Birthplace

Mt. Forest Conn.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name Robert Scott

MOTHER

13. Birthplace Scotland

14. Maiden name

Mary Ann Reed

15. Birthplace

Canada

16. Informant

Henry C. Howell

Address

7611 Eastern Ave, Takoma Park Md.

17. Burial

Shipment to caskets date thereof Feb. 10, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt Pleasant

Location

Newark, New Jersey

18. Funeral director

Warren E. Humphrey

Address

Silver Spring Md.

19. Date rec'd by registrar

Feb. 9th 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7611 Eastern Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 8 1945 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. Med Exam care 1945

and that I last saw her alive on 1945

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

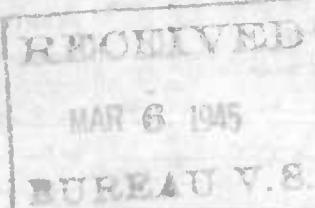
Injured at work?

23. SIGNATURE

Frank J. Brochart M.D.Sept. Med Exam

M. D. or other

Address Garrisonburg Md. Date signed 2-8-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01887

CERTIFICATE OF DEATH

Reg. Distr. No. 716

1. PLACE OF DEATH:

County.....*Montgomery*
 City or town.....*Rosemont, Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*12 years*

Hospital, Institution, or street address where death occurred:

137 Garrett Park Rd.

How long in hospital or institution?.....

3. (a) FULL NAME

Michael Wade Hughes

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<i>Male</i>	<i>white</i>	<i>married</i>

6. (b) Name of husband or wife.....*Bertha*7. Birth date of deceased (mo., day, yr.).....*July 20, 1876*

8. AGE: Years	Months	Days	Less than one day
<i>68</i>	<i>7</i>	<i>0</i>	hrs. min.

9. Birthplace.....*Poolesville, Md.*

(Town, county, and state)

10. Usual occupation.....*Laboratory Technician, Nail Inst.*

11. Industry or business

12. Name.....*William D. Hughes*13. Birthplace.....*Montgomery Co. Md.*14. Maiden name.....*Elizabeth Connelly*15. Birthplace.....*Montgomery Co. Md.*16. Informant.....*Mrs. Bertha Hughes*Address.....*137 Garrett Park Rd. Kensington, Md.*17. Burial.....*Burial* Date thereof.....*2/23/45*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....*Forest Oak Cemetery*Location.....*Gaithersburg, Maryland*18. Funeral director.....*John Penberth Humphrey*Address.....*7551 Wisconsin Ave. Bethesda, Md.*19.*2/27/45* Wm E. Jones
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.* County.....*Montgomery*
 City or town.....*Rosemont, Md.*
(If outside city or town limits, write RURAL and give nearest town)
 Street No.....*137 Garrett Park Rd.*
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

225-05-4087

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Feb 20 1945* at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med Exam Case to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death.....

Coronary occlusion DURATION *died suddenly*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

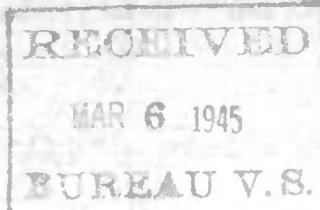
Means of injury.....

Injured at work?

23. SIGNATURE.....*Frank J. Broschart M.D.**Dep Med Exam*

M. D. or other

Address.....*Gaithersburg, Md.* Date signed.....*2-20-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21

CERTIFICATE OF DEATH

01888
Reg. Dist. No. 223-

1. PLACE OF DEATH: MONTGOMERY
 County
 City or town TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred: 507 CARROLL AVE.
 How long in hospital or institution? 4 YRS.

3. (a) FULL NAME

JAMES ALBERT

4. Sex <u>M.</u>	5. Color or race <u>W.</u>	6. (a) Single, married, widowed, or divorced <u>Widowed.</u>
6. (b) Name of husband or wife <u>Brown Jester</u>		
7. Birth date of deceased (mo., day, yr.) <u>Dec 2, 1856</u>		6. (c) If alive, give age years

8. AGE: Years 88 Months 3 Days 15. If less than one day
 hrs. min.

9. Birthplace Marshall County Ind.
 (Town, county, and state)

10. Usual occupation Retired Butcher

11. Industry or business Cabinet Jester

MOTHER FATHER
 12. Name Calvert Jester
 13. Birthplace Ind.

MOTHER
 14. Maiden name
 15. Birthplace
 16. Informant Emmet Jester

Address 508 Carroll Ave
 17. Burial Date thereof Feb 20, 1958
 (Burial, cremation, or removal. Which?) Data thereof (month) (day) (year)

Cemetery or crematory
 Location South Bend Indiana.

18. Funeral director Jesus Deller

Address 257 Carroll St. N.W. Wash.
 19. Date rec'd by registrar 2/17 1945 John Deller
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County MONTGOMERY
 City or town TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 507 CARROLL AVE.
 (If rural, give LOCATION)

2. (a) If veteran, name war
 3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 8 1941 to Feb. 17 1945 and that I last saw him alive on Feb. 17 1945.

Immediate cause of death Congestive Heart Failure Duration 2 days

Due to Atherosclerosis Indirect

Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

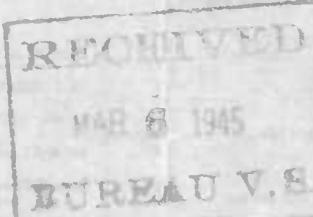
Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?
 23. SIGNATURE O. Blatt, M.D. M. D. or other

Address 6911 5th St. N.W. Date signed Feb. 17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50 X

01889

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery
Olney, rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Elizabeth Ogle Johnson

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

WIDOWED.

6. (b) Name of husband or wife

ROBERT S.

7. Birth date of

deceased (mo., day, yr.)

APR - 17 - 1868

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76

10

2

hrs.

mio.

9. Birthplace

WASH. DC.

(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

12. Name *REZIN H. OGLE*13. Birthplace *WASH. DC*14. Maiden name *MARGARET WELLS*15. Birthplace *OHIO*18. Informant *MR. AMBROSE DURKIN*Address *PORTNER APTS - WASH DC.*

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof *FEB 22 45*

(month) (day) (year)

Cemetery or crematory *GEO. WASH MEM'L*Location *Riggs Romo - Pr. GEO'S Co.*18. Funeral director *WARNER E PURPHREY*Address *843 Ga Ave - Silver Spring, Md*19. *Feb. 20 1945 Josephine in Schaeffer*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Montgomery

County.....

City or town.....

Olney

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Brookville Rd - in Olney Qua.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 19 1945 at 8A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*August 1944 to Feb 19 1945*and that I last saw her alive on *February 18 1945*

Immediate cause of death

*Carcinoma of left breast
with generalized metastasis*

Due to

Due to

Other conditions

none

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

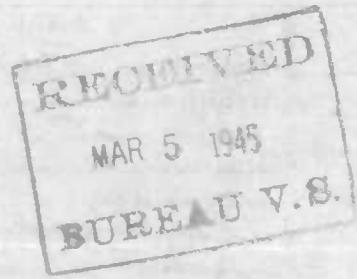
23. SIGNATURE

John J. Fauthing, M.D.

M. D. or other

Address

*Rockville, Md.*Date signed *2/19/45*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

01890

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 8 days
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 months 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1926 21st Place, S.E.
(If rural, give LOCATION)

3. (a) FULL NAME
KIRSCH, Gladys

3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>W-US</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
-------------------------	---------------------------------	---

6.(b) Name of husband or wife John Kirsch, CGM USN

7. Birth date of deceased (mo., day, yr.) Jan 6, 1900 6.(c) If alive, give age years

8. AGE: Years <u>45</u>	Months <u>1</u>	Days <u>3</u>	If less than one day hrs. min.
----------------------------	--------------------	------------------	--------------------------------------

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Daniel Gibbons
13. Birthplace Maryland

MOTHER
14. Maiden name Mepina Stansberry
15. Birthplace Maryland

16. Informant husband: Mr. John Kirsch,
Address 1926 21st Place., S. E., Wash., D.C.

17. burial Date thereof 2-12-45
(Burial, cremation, or removal: Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery

Location Washington, D.C.

18. Funeral director Lee Funeral Home

Address 4th & Mass., Ave., N.E., Wash., D.C.

19. 9 Feb. 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9th 19⁴⁵, at 7.50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31st 19⁴⁴ to Feb. 9th 19⁴⁵ and that I last saw her alive on Feb. 8th 19⁴⁵

Immediate cause of death Typhoid Tenssive Heart Disease with Congestive Failure DURATION 10 years

Due to:

Due to:

Other conditions Possible Malignancy of Left Breast.
(Include pregnancy within 8 months of death)

Major findings of operations None. Date of op. _____

Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

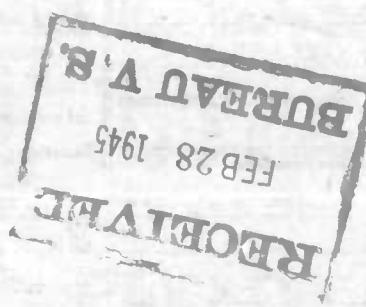
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Gwendolyn R. Smith M. D. or other _____

Address U.M.C. Bethesda Date signed Feb. 9 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01891

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

76 yrs.

Hospital, Institution, or street address where death occurred:.....

Home

How long in hospital or institution?.....

3. (a) FULL NAME

Carrie Savila Kohlhase

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Harry Kohlhase

8. (c) If alive, give age..... years

65

7. Birth date of deceased (mo., day, yr.)

Oct. 20, 1880

8. AGE:

64

Years

Months

Days

If less than one day

0 hrs. min.

9. Birthplace.....

Rockville, Montg. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Housekeeping

FATHER

12. Name.....

John Pearl

MOTHER

MOTHER

13. Birthplace.....

Unknown

14. Maiden name.....

Savila Delby

15. Birthplace.....

Unknown

16. Informant.....

Mrs. Charles Kohlhase

Address.....

Rockville, Md.

Burial

Date thereof..... Oct. 21, 1945

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Montgomery Cemetery

Location.....

Beallsville, Md.

Funeral director.....

Barnesbury, Md.

Address.....

Barnesbury, Md.

Date rec'd by registrar.....

Feb. 19, 1945.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Feb. 19 - 1945 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 17 - 1945 to Feb. 19 - 1945

and that I last saw her alive on Feb. 19 - 1945

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

2 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

B. D. White, M.D.

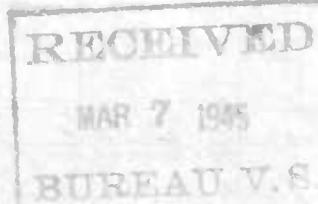
M. D. or other

Address..... Rockville, Md.

Date signed..... Feb. 19, 1945

RECEIVED MAR 7 1945

U.S. GOVERNMENT PRINTING OFFICE: 1945 10-140741



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *K3-m*

01892

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County

Bethesda, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 days*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Martin Krost

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

married

6.(b) Name of husband or wife

Reich

7. Birth date of deceased (mo., day, yr.)

June 16, 1911

B.(c) If alive, give age

years

8. AGE: Years

Months

Days

If less than one day

33

8

5

hrs.

mo.

9. Birthplace

St. Louis, Mo.

(Town, county, and state)

10. Usual occupation

Economist

11. Industry or business

MOTHER FATHER

12. Name

Mox Krost

MOTHER FATHER

13. Birthplace

St. Louis, Mo.

MOTHER FATHER

14. Maiden name

Vera S. Pieter

MOTHER FATHER

15. Birthplace

St. Louis, Mo.

16. Informant

Emile DeGres-

Address

*Shipment*Date thereof *2/24/45*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Houston, Texas.

Location

Texas -

18. Funeral director

Clem Ruben Humphrey

Address

*1557 Wis. Ave. Bethesda,*19. *2-24-45*

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *D.C.*

County

Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. *1445 Otis Pl. N.W.*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 21

1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Def. Med. Exam care*and that I last saw him alive on *19*

Immediate cause of death

*Arteriosclerosis due to carbon monoxide gas*Due to *gasoline (smoke)*Due to *bad house extending from exhaust to face*

Other conditions

(Indicate pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *murder*Date of *2-23-45*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

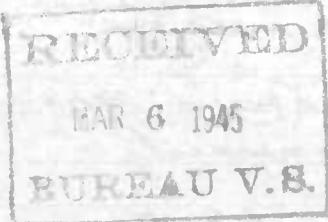
Injured at work?

23. SIGNATURE

Frank J. Broshart M.D.

M. D. or other

*def. fed Exam*Address *Guthenberg Md.* Date signed *2-23-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01893

Reg. Dist. No. 213

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
 County Montgomery
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months
 Hospital, institution, or street address where death occurred:
Just here
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 101 S. Washington St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Edith Stoustrup Lamar

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
----------------------	-------------------------------	---

8. (b) Name of husband & wife George H. Lamar

7. Birth date of deceased (mo., day, yr.) June 20, 1871

8. AGE: Years 73 Months 5 Days 14 If less than one day — hrs. — min.

9. Birthplace Rockville Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name Edward E. Stoustrup

13. Birthplace Montg. Co., Md.

14. Maiden name Martha Rebecca Barr

15. Birthplace Maryland

16. Informant Mrs. Louise L. Bryant (daughter)

Address Sykesburg, Pa.

17. Burial Burial Date thereof Feb. 6, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or columbarium Rockville Union

Location Rockville, Md.

18. Funeral director Warren E. Pumphrey

Address Silver Spring, Md.

19. Date rec'd by registrar Feb. 5 1945

(Date rec'd by registrar) Josaphine D. Hartman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1928 15. to Feb. 4 1945,
 and that I last saw her alive on Feb. 4 1945.

Immediate cause of death

acute myocarditis fatalis DURATION
months

Due to

Myocarditis, chronic DURATION
years

Due to

none DURATION
 (Include pregnancy within 8 months of death)

Other conditions none Date of op.

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

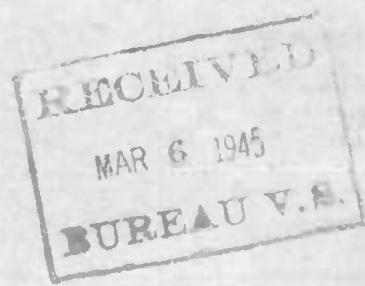
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Hartman M.D. M. D. or other

Address Rockville, Md. Date signed 2/4/45



PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Red)*

01894

216

Reg. Diat. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County *Montgomery*City or town *Bethesda*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*Suburban*How long in hospital or institution? *1 hour 30 minutes*

3. (a) FULL NAME

Edward Dawson

4. Sex

M

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Feb. 19, 1862*

6.(c) If alive, give age years

8. AGE:

Years *82*

Months

Days *3*

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state) *Virginia*

10. Usual occupation

Farm hand

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Feb 26 1945*

(month) (day) (year)

Cemetery or crematory

Lincoln Park Cemetery

Location

Rockville, Md.

18. Funeral director

Robert L. Snowden

Address

246 N. Wash. St, Rockville,

19. 2-26-45

(Date rec'd by registrar)

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Montgomery*City or town *Boyds, Md.*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23

1945 av 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med Exam Case to *19*
and that I last saw him *alive* on *19*

Immediate cause of death

Acute myocarditis

DURATION

1/2 hrs.

Due to

Chronic valvular heart disease *2 yrs.*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

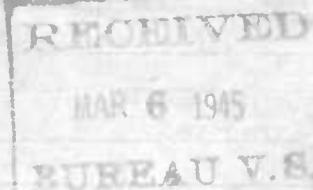
Injured at work?

23. SIGNATURE

Frank J. Brochard M.D.

(If not a physician, check M. or other)

Address *Matthewsburg Rd.* Date signed *2-23-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth of deceased
is shown on
FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BIO)

01895

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH

County

Montgomery
Barnsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Catherine Rebecca Lay

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white

Widow

6.(b) Name of husband or wife

Claude Edgar Lay

7. Birth date of

deceased (mo., day, yr.)

85 April 2 - 1860 1859

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day

85

10

23

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

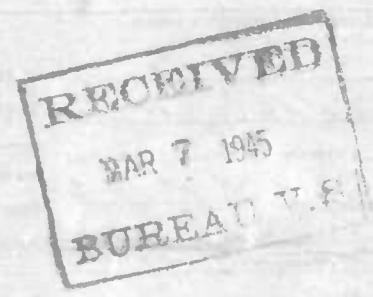
Home

MOTHER FATHER

William W.C. Cony

Loudon County, Va.

Elizabith Unknown



PLEASE WRITE PLAINLY, WITH ~~INK~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9th

01896

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Colesville Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....35 yrs -Hospital, institution, or street address where death occurred:.....Colesville, Md.

How long in hospital or institution?.....

3. (a) FULL NAME

Charles Edward Lechler, Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>white</u>	<u>married</u>

6. (b) Name of husband or wife	Mary Elizabeth
--------------------------------	----------------

7. Birth date of deceased (mo., day, yr.)	Dec. 29, 1881
---	---------------

8. AGE:	Years	Months	Days	If less than one day
<u>63</u>				hrs. min.

9. Birthplace	Baltimore, Maryland
(Town, county, and state)	

10. Usual occupation	Farmer
----------------------	--------

11. Industry or business	Charles E. Lechler
--------------------------	--------------------

12. Name	Charles E. Lechler
13. Birthplace	Maryland

14. Maiden name	Amelia Johnson
15. Birthplace	Maryland

16. Informant	Mrs. Mary Elizabeth Lechler
---------------	-----------------------------

Address	Colesville, Md.
---------	-----------------

17. Burial	Date thereof..... <u>2/11/45</u> <small>(Burial, cremation, or removal. Which?)</small>
------------	--

Cemetery or crematory	Colesville Cemetery
-----------------------	---------------------

Location	Colesville, Maryland
----------	----------------------

18. Funeral director	Leon Ruben Humphrey
----------------------	---------------------

Address	7357 Wisconsin Ave., Bethesda, Md.
---------	------------------------------------

19. Date rec'd by registrar	Feb. 10 1945
-----------------------------	--------------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Montgomery Co.

City or town.....Colesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.....Colesville, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....Feb. 9, 1945

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 16 1939 to 2-9-45 1945and that I last saw h... am alive on 2-9-45Immediate cause of death.....Coronary ThrombosisDURATION 20 min

Due to.....Recurrent attacks of Coronary Thrombosis due to arteriosclerotic heart disease

Due to.....③ Generalized arteriosclerosis

Other conditions.....④ Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

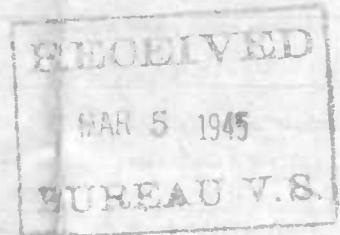
Injured at work?

23. SIGNATURE.....Joseph P. Laughlin M.D.

M. D. or other

Address.....1000 Rock Creek PlazaDate signed.....2/10/45

M.D.



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK: Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

2431
01897

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County

City or town

Montgomery

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Silverman Hospital

How long in hospital or institution?

12 days

3. (a) FULL NAME

Mrs. Goldie Lee

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widowed

6. (b) Name of husband or wife

Edward Lee

7. Birth date of deceased (mo., day, yr.)

Feb. 14, 1892

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

52

11

23

hrs.

min.

9. Birthplace

Cathartin, Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Eras. Catoe

MOTHER

13. Birthplace

Virginia

14. Maiden name

Alvira Ayers

Virginia

15. Birthplace

Mrs. Margaret Lee Beeson

Same

16. Informant

Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/9/45
(month) (day) (year)

Cemetery or crematory

Uppererville, Va. Cemetery

Location

Uppererville, Va.

18. Funeral director

Elton Reuben Humphrey

Address

1557 Wisconsin Ave. Bethesda

19. Date rec'd by registrar

2/8 1945 Mrs E. J. Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4626 Reseda Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 6, 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Jan. 23, 1945, to Feb. 6, 1945,

and that I last saw her alive on Feb. 6, 1945.

Immediate cause of death

Intestinal obstruction

Due to adhesions from previous operations

not due to cancer.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

F. G. Bauerfield, Jr.
Bethesda, Md.

M. D. or other

Date signed

RECEIVED
MAR 6 1945
BUREAU V.S.

M
 PLEASE WRITE PLAINLY, WITH UNFILLED INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

01898

CERTIFICATE OF DEATH

Reg. Dlat. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 months & 20 days

Hospital, institution, or street address where death occurred:

US NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution?..... 3 months & 20 days

3. (a) FULL NAME

LOEFFLER, Vincent Aloysius, Ensign C-V(S) USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

B.(b) Name of husband or wife..... Mrs. Fern Loeffler

7. Birth date of deceased (mo., day, yr.)..... 17 Nov. 1914

8. AGE: Years	Months	Days	If less than one day
30	3	10	hrs. min.

9. Birthplace..... Pa. (Town, county, and state)

10. Usual occupation.....

11. Industry or business..... Navy

12. Name..... George Loeffler

13. Birthplace..... Germany (deceased)

14. Maiden name..... Louise Naab

15. Birthplace..... Germany

16. Informant..... Wife: Mrs. Fern Loeffler

Address..... 1100 Linden Place, Pittsburgh, Pa.

17. removal..... Date thereof..... 2-27-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Mary's Cemetery

Location..... Pittsburgh, Pa.

18. Funeral director..... W. W. CHAMBERS, 1 Jm^o

Address..... 1100 Chapin St. N. W. Wash. D.C.

19. 2-27-..... 1945..... Mary Charlotte Smith
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pa.

County.....

City or town..... Pittsburgh

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1100 Linden Place

(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 27 Feb.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 7 1944 to 27 Feb. 1945 and that I last saw him alive on 27 Feb. 1945.

Immediate cause of death.....

Respiratory paralysis

DURATION

Due to..... Brain tumor

4

Due to.....

Malignant glioma

5

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Malignant glioma
Brain tumor Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

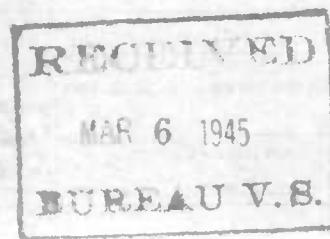
Means of Injury

Injured at work?

23. SIGNATURE.....

J. W. Chamberlain M. D. or other

Address..... 1100 Linden Place, Pittsburgh, Pa. Date signed 2/27/45



VS A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01899

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County Montgomery, Md.
City or town Cabin John, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.Hospital, institution, or street address where death occurred: Mc Arthur Blvd & 7 Locks Rd.

How long in hospital or institution?

3. (a) FULL NAME

Thomas William Lynch

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Dora L.7. Birth date of deceased (mo., day, yr.) June 28, 1885 - 1875 6.(c) If alive, give age 55 years8. AGE: Years 69 Months Days If less than one day hrs. min. 9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Martin Lynch13. Birthplace Montgomery Co.14. Maiden name Susie Davies15. Birthplace Montgomery Co.16. Informant wifeAddress Same17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 2/10/45 Month (day) (year)Cemetery or crematory Rock Creek Cem.Location Washington, D. C.18. Funeral director Rev Arthur HumphreyAddress 7557 Wisconsin Ave. Bethesda, Md.19. 2/13/45 1945 Wm E. John, M.D. Registrar
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Cabin John, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Mc Arthur Blvd., 7 Locks Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945 at 79 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 12 - 1945 to Feb. 7, 1945and that I last saw him alive on Feb. 7, 1945

Immediate cause of death

Coronary occlusion DURATION 3 wks.Due to Chr. cardio-vascular disease 5 YR.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. G. Baumfeld, M.D. M. D. or other
Address Bethesda, Md. Date signed 2/7/45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK,
Supply every item of information carefully. The correct age
is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01900

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 24 hours

3. (a) FULL NAME

Hena Markowitz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Jewish married

6. (b) Name of husband or wife Samuel Markowitz

7. Birth date of

deceased (mo., day, yr.) December 26, 1879

8. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

66 2 2

hrs. min.

9. Birthplace Kishinev, Russia
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name JACOB KAUFMANN13. Birthplace Russia14. Maiden name Yekta Karp15. Birthplace Russia16. Informant Washington Sanitarium and Hospital RecordsAddress Takoma Park, Maryland

17. Removal

Date thereof Mar 11 1943
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location Washington All18. Funeral director B Danzansky & SonAddress 350 S - 14th St

19. March 1 1943

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County MontgomeryCity or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)Street No. 906 S. Oak Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/28/

19 45 9³² P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1942

to Feb 28 1943

10 45

and that I last saw her alive on Feb 28 1943

19 45

Immediate cause of death

Myasthenia gravis
with Cerebral edema

DURATION

3 years

Due to

Sclerosis

Died to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

O

PHYSICIAN: Please underline the cause to which death should be charged statistically.

O

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

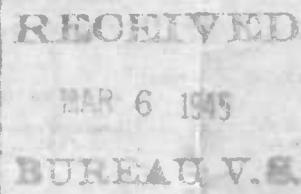
Dr. A. Holzer M.D.

M. D. or other

Address 500 Piedmont St NW

Date signed

2/28/45



Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

01901

FILM NO. G 94 APR 13 1945

Reg. Dist. No. 213

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

City or town.....

Maryland Rockville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

32 years

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?.....

3. (a) FULL NAME

Annie B

4. Sex

Female	5. Color or race	6.(a) Single, married, widowed, or divorced
	English	married

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)	6.(c) If alive, give age..... years
August 30 1874	76

8. AGE:

Years	Months	Days	If less than one day
70	7	0	hrs. min.

9. Birthplace.....

London, England	(Town, county, and state)
-----------------	---------------------------

10. Usual occupation.....

House wife

11. Industry or business

John Bailey

12. Name.....

Unknown

13. Birthplace.....

Unknown

14. Maiden name.....

Annie

15. Birthplace.....

Unknown

16. Informant.....

William E. Martin

Address

Rockville, Md (Haiti)

17. Burial.....

Burial	Date thereof	(month)	(day)	(year)
	Feb 4, 1945			

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Haiti

Location.....

Rockville, Md

18. Funeral director.....

Robert L. Snaydown

Address

246 N. Wash. St.

24

(Date rec'd by registrar)

1945 Josephine D. Hartman

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

*Martin**none*

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

February 1 1945	at 8:30 P.M.
-----------------	--------------

January 30 1945	only.
-----------------	-------

and I last saw her alive on Jan. 30 1945.

Immediate cause of death.....

Inocardinal failure	DURATION for days
---------------------	----------------------

Due to.....

Due to.....

Other conditions.....

{ Senile dementia	DURATION several years
alzheimer's	
malaria	

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

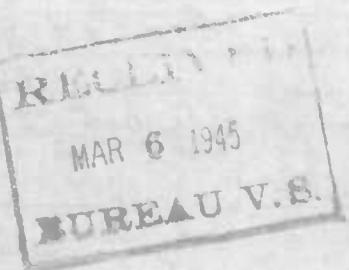
Means of injury..... Injured at work?

23. SIGNATURE.....

Wm J. Hartman	MD.
---------------	-----

M. D. or other	Date signed
----------------	-------------

Rockville, Md	Feb 4, 1945
---------------	-------------



✓ PLEASE WRITE PLAINLY, WITH CONFLADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

01902

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

6 days

3. (a) FULL NAME

Clement Martin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored married

6. (b) Name of husband or wife

Jamie

7. Birth date of deceased (mo., day, yr.)

April

6. (c) If alive, give age

1880 years

8. AGE:

Years

Months

Days

If less than one day

64 10

hrs. min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Thomas Martinis

FATHER

12. Name

Rockville, Md.

13. Birthplace

Brooklyn

14. Maiden name

Washington, D.C.

15. Birthplace

Bernice Orley

16. Informant

Rockville, Md.

Address

17. Burial

BethesdaDate thereof Feb 20 1945

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Haiti Cemetery

Location

Rockville, Maryland

18. Funeral director

Robert L. Snodgrass

Address

246 N. Wash. St. Rockville19. 2/2019 45

Date rec'd by registrar

2/15/45

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville (If outside city or town limits, write RURAL and give nearest town)Street No. Box 173 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14, 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-8-1945 to 2-14-1945and that I last saw him alive on 19

Immediate cause of death

Congestive heart failure

DURATION

Due to TheresaChronic nephritisDue to Duration: Indefinite

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

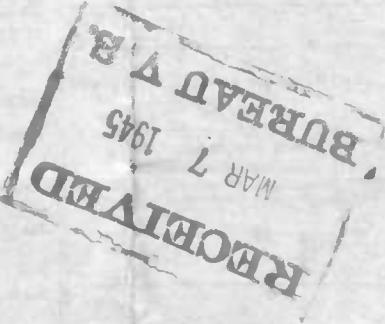
Means of injury

Injured at work?

23. SIGNATURE Ward W. Welsh

M.D. or other

Address 1045 Wash. - Rockville, Md. Date signed 2/14/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

01903

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: MONTGOMERY
County

City or town... TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

7201 Takoma Ave

How long in hospital or institution?

3. (a) FULL NAME

SAMUEL K. Mc CALL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W M

6. (b) Name of husband or wife PAULINE

APRIL 9, 1896 6. (c) If alive, give age years
7. Birth date deceased (mo. day, yr.)8. AGE: 68 Years Months Days If less than one day
hrs. min.

9. Birthplace P.A. (Town, county, and state)

10. Usual occupation LAWYER

11. Industry or business HUGH Mc CALL

12. Name HUGH Mc CALL

13. Birthplace ✓

14. Maiden name ✓

15. Birthplace ✓

16. Informant MRS W. G. CAPTELL

Address 7701-TAKOMA, AVE.
REMOVAL Date thereof 2-23-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington, D.C.

Location The S. J. Hines Co.

18. Funeral director

Address 2901-14 St. Wash. D.C.

19. Feb 73 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State

MD County MONTGOMERY

City or town

TAKOMA PARK (If outside city or town limits, write RURAL and give nearest town)

Street No.

7701-TAKOMA AVE (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept Med Exam Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death

coronary occlusion

Due to

cardiac degeneration

Due to

DURATION

death suddenly

2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

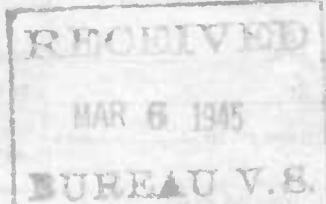
Frank J. Brockert M.D. M.D. or other

Address

J. H. Hines Co. Date signed 2-23-45

MEMORANDUM FOR THE
DEPARTMENT OF STATE, WASHINGTON

RECORDED MAIL



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

01904

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

3. (a) FULL NAME

MC CARTIN, Clifford Clarence, Lt. (jg) O-V(S) USNR

3. (b) Social Security Number

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married
----------------	--------------------------	--

8.(b) Name of husband or wife..... Mrs. Betty McCartin

7. Birth date of deceased (mo., day, yr.)..... 1 August 1906

8. AGE: Years 38	Months 6	Days 22	If less than one day hrs. min.
---------------------	-------------	------------	---

9. Birthplace..... Ill. (Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business

FATHER 12. Name..... John McCartin

13. Birthplace..... Md.

MOTHER 14. Maiden name..... Jennie Wright

15. Birthplace..... Ill.

16. Informant..... Wife: Mrs. Betty McCartin

Address 5232 Kynd So., Euclid, Ohio

17. Burial..... Date thereof..... 3-14-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W. W. Chambers

Address 1400 Chapin St., N.W., Wash., D.C.

19. 3-12 45 Mary Elizabeth Smith
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Ohio County.....

City or town..... Euclid,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5232 Kynd So.

(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 23 1945 -

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. med. exam care to 19.
and that I last saw him alive on 19.

Immediate cause of death.....

Suffocation by hanging
(Suicide)

Due to.....

DURATION

Final
hang
to

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide Date of 2-23-45

Where did injury occur? Bethesda County Mc (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

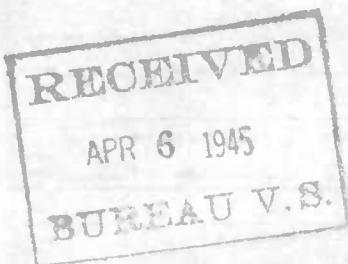
Injured at work?

23. SIGNATURE..... Frank J. Brochart M. J.

Def. med. Exam

M. D. or other

Address..... Galveston, Md. Date signed 3-12-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

CERTIFICATE OF DEATH

01905
Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Montgomery
 City or town... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanatorium HospitalHow long in hospital or institution? 3 mo 18 days

3. (a) FULL NAME

Mr. James McGowan

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widowed

6. (b) Name of husband or wife

Mary Connell

(Deceased)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1873

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

New York City N.Y.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Government Worker

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Records, Wash. Sanatorium Hospital

Address

Takoma Park, Md.

17. Removal

Feb. 18, 1945

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Washington, D.C.

Location

" "

18. Funeral director

J.W. Lee Jr. & Co

Address

300-4 st N.E. - Wash. D.C.

19. Date rec'd by registrar

Feb. 181945Josephine Dr. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 608 Carroll Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 26, 1941 to Feb. 18, 1945and that I last saw him alive on Feb. 17, 1945

Immediate cause of death

Asthma (bronchial)

DURATION

40 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

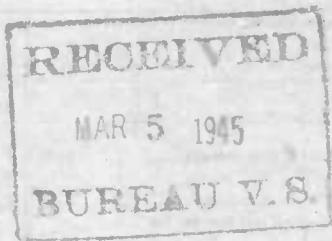
Injured at work

23. SIGNATURE

J.H. O'Neill, M.D.

M. D. or other

Address Silver Spring, Md. Date signed 2-18-45



M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01906

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH:

County Montgomery CountyCity or town Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 15 days

Hospital, Institution, or street address where death occurred:

Washington InstitutionHow long in hospital or institution? 1 month 15 days

3. (a) FULL NAME

Mildred Miller

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white married

6.(b) Name of husband or wife John Charles Miller

7. Birth date of deceased (mo., day, yr.)

January 7, 1900

6.(c) If alive, give age 49 years

8. AGE:

Years 45 yrs Months 1 Day 13 If less than one dayhrs. min. 9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation

Housewife11. Industry or business at home12. Name Lowell C. Shattuck13. Birthplace Lowell, Mass.14. Maiden name Jessie Lucy15. Birthplace Baltimore, Maryland16. Informant Washington & Southern RecordsAddress Takoma Park, Md.17. Removal Date thereof 1/20/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D. C.18. Funeral director Haines Co.Address 2901 - 14th, N.W., Washington, D.C.19. Date rec'd by registrar Feb. 20, 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of ColumbiaCity or town Washington D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1335 Glenlock St. NW

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945 at 10 3/4 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.45 to Feb 20 1945and that I last saw her alive on Feb 20 1945

Immediate cause of death

Circulatory Failure DURATION 20 hrs.Due to Cerebral Hemorrhage 6 da.Due to Acute Hypertension withneurological deficit 7 da ago

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

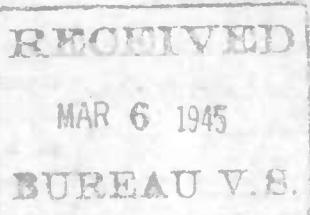
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Arthur Katz MD M. D. or otherAddress Wash San End Hospital Date signed 2/20/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 142

CERTIFICATE OF DEATH

01907
Reg. Dist. No. 213.

1. PLACE OF DEATH:

County... Montgomery

City or town... Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 yrs.

Hospital, Institution, or street address where death occurred:
402 Monroe St.

How long in hospital or institution?

3. (a) FULL NAME

Walter Wilson Nicholson

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Leondale W. Nicholson

7. Birth date of deceased (mo., day, yr.) June 27 - 1897
6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

47 7 16 hrs. min.

9. Birthplace... Montg Co. Md.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name... Leonda M. Nicholson

13. Birthplace Maryland

14. Maiden name Florence Watkins

15. Birthplace Maryland

16. Informant Leonda T. Nicholson

Address 402 Monroe St. Rockville, Md.

17. Burial Date thereof 2/14/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Grove Salem Church Cem-

Location Cedar Grove, Md.

18. Funeral director Wm. Gubben Broomey

Address 7557 Wisconsin Ave. Bethesda, Md.

19. Date rec'd by registrar 2/13/45

Josephine D. Footer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Montg.

City or town... Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No... 402 Monroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dr. Med. Examin. Case 19.

and that I last saw him alive on 19.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D.

Dep. Med. Exam. M. D. or other

Address 1416 University Blvd. Date signed 2-12-45

WISCONSIN STATE LIBRARIES



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

01998

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Rural - Germantown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3½ years

Hospital, institution, or street address where death occurred: Seneca

How long in hospital or institution?.....

3. (a) FULL NAME

George Henry Nickens

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Separated

6.(b) Name of husband or wife..... Martha Jane

7. Birth date of deceased (mo., day, yr.)

10-9-66

8.(c) If alive, give age..... years

8. AGE: Years

78

Months

4

Days

4

If less than one day

hrs.

min.

9. Birthplace.....

Lloyd's, Essex Co., Va.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... William Nickens

13. Birthplace.....

14. Maiden name..... Mary Monday

15. Birthplace.....

16. Informant..... Montgomery County Welfare Board

Address..... Rockville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Feb 15, 1945
(month) (day) (year)

Cemetery or crematory.....

Location..... Norlack Cemetery, Maryland

18. Funeral director..... Robert L. Johnson

Address..... 246 N. Wash. St. Rockville

19. Feb. 14 1945 Aboda L. Coche

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Montgomery

City or town..... R.F.D. Germantown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Seneca

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2/18/45 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1944 to Feb. 11 - 1945
and that I last saw him alive on Feb. 11 - 1945

Immediate cause of death.....

Acute heart failure

DURATION

2 days

Due to..... Intestinal Hemorrhage

7 mo.

Due to..... Senility

6 years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

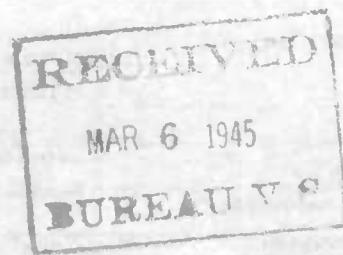
Injured at work?

23. SIGNATURE..... William C. Miller, M.D.

M. D. or other

Address..... Feb. 13 - 45 Gaithersburg, Md.

Date signed.....



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

01999

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 Suburban Hospital
 How long in hospital or institution? 30 hours

3. (a) FULL NAME

John A. Norris

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married
6.(b) Name of husband or wife..... Hannah J. Norris		

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1888
 6.(c) If alive, give age years

8. AGE:	Years	Months	Days	If less than one day
	56	5	8	hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)

10. Usual occupation..... Carpenter

11. Industry or business

MOTHER FATHER	12. Name..... John William Norris
	13. Birthplace..... Maryland
	14. Maiden name..... Ida Mathews
	15. Birthplace..... Maryland

16. Informant..... Nellie Mae Norris
 Address 905 City Rd., Rockville Md.

17. Burial Date thereof 2/24/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery
 Location Rockville, Md.

18. Funeral director Wm. (Deacon) Humphrey
 Address Rockville, Maryland.

19. 2/22/45 M. D. or other
 (Date rec'd by registrar) M. D. or other
 Registrars signature

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State... Maryland County... Montgomery
 City or town... Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 905 City Road
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Feb - 21, 1945, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..., to 19...

and that I last saw h... alive on 19...

Immediate cause of death..... Interventricular hemorrhage, massive

Due to..... Cerebral arteriosclerosis +
 Hypertension

Due to..... Branchial artery

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.

Date of op.
 Autopsy results..... See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

Richard E. Kelso, M.D.

M. D. or other
 Address 800 Old Georgetown Rd Date signed 2-24-45

getherd, dated

RECEIVED
MAR 6 1945
BUREAU V.S.

~~MARYLAND STATE DEPARTMENT OF HEALTH~~
 PLEASE WRITE PLAINLY, WITH ~~INK~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92D

01910

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MONTGOMERY

City or town TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

507 CARROLL AVE

How long in hospital or institution?

3. (a) FULL NAME

ORA OSTRANDER.

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced WIDOWED

8. (b) Name of husband or wife Mrs. OSTRANDER.

7. Birth date of deceased (mo., day, yr.) APRIL 3, 1854. 8. (c) If alive, give age years

8. AGE: Years 90 Months 10 Days 24 If less than one day hrs. min.

9. Birthplace HOLLY, MICHIGAN. (Town, county, and state)

10. Usual occupation AT HOME

11. Industry or business

FATHER 12. Name W.W. Lockwood

13. Birthplace MICHIGAN.

MOTHER 14. Maiden name ?

15. Birthplace

16. Informant CLARA WITKE.

Address 507 CARROLL AVE.

17. Burial GLENWOOD CEMETERY Date thereof MAR. 3 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location WASHINGTON D.C.

18. Funeral director J. Arthur Balling

Address 254 Carroll St. N.W., Takoma Park, Md.

19. Feb 28 1945
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MONTGOMERY

City or town TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27th 1945 at 150 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1936 to Feb 27, 1945

and that I last saw h. alive on 18.

Immediate cause of death Senility (9 yrs) and

Myocardial failure

Due to Chr. myocardial degeneration 9 yrs

Valvular insufficiency 9 yrs

Due to

Other conditions Bronchial asthma 9 yrs

Ch. Bronchitis 9 yrs

(Include pregnancy within 3 months of death)

Major findings or operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. John D. D.D.S. M. D. or other

Address 7894 Ga Ave. Silver Spring 2-2845

Md. Date signed

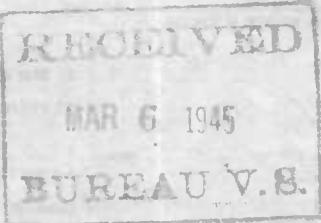
Registrar

WILAYAH OF IRANIAN AND STATE GRATEAM

TELEGRAM NO. 1000

TELEGRAM TO SHAGHARIMED.

TELEGRAM TO SHAGHARIMED.



~~PLEASE WRITE PLAINLY WITH UNFADING INK.~~ Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

CERTIFICATE OF DEATH

01911
Reg. Dist. No. 223-

1. PLACE OF DEATH:

County MONTGOMERY

City or town TAKOMA PARK, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

WASHINGTON SANITARIUM

How long in hospital or institution?

3. (a) FULL NAME

JAMES HUGH PARSONESE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

W.

Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) APRIL 14, 1944.

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

9

29

hrs.

min.

9. Birthplace:

Washington, D.C.

(Town, county, and state)

10. Usual occupation:

11. Industry or business

MOTHER FATHER

PETER PARSONESE.

NEWARK, N.J.

13. Birthplace

14. Maiden name

15. Birthplace

MARY McBRIDE

MOREA, PENNA.

16. Informant:

PETER PARSONESE

Address 6513 FLANDERS DRIVE, HAMPSHIRE KNOTTS.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof FEB. 16, 1945

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

Feb. 14

1945

J. W. Williams

Reg. No.

(Date rec'd by registrar)

19. (Date signed)

1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County PRINCE GEORGES.

City or town HAMPSHIRE KNOTTS.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6513 Flanders Drive

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1945, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14, 1944, to Feb. 13, 1945,

and that I last saw him alive on Feb. 13, 1945.

Immediate cause of death Cardiac dilatation as

result of congenital heart disease

DURATION 6 hrs.

Due to Acute bronchitis

2 days

Due to:

Other conditions Weak debilitated infant

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

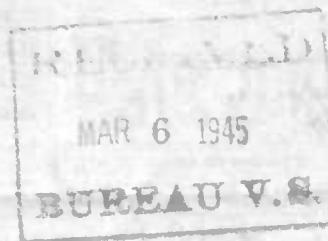
M. D. or other

Address 113 Carroll St., Takoma Park, D.C.

Date signed Feb. 13, 1945

STATED TO THOMASIAN STATE GOVERNOR

NOTICE TO ATTACHED



M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians, please write the causes of death clearly and legibly. It is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Signature)*

01912

CERTIFICATE OF DEATH

Reg. Dist. No. *214*

1. PLACE OF DEATH:
County **Montgomery**

City or town **Silver Spring, Md.**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **since October 1944**

Hospital, Institution, or street address where death occurred:
H 1608 No. Springwood Drive

How long in hospital or institution? **none**

3. (a) FULL NAME
Caroline Georgianna Picard

4. Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced
single

6.(b) Name of husband or wife **none**

7. Birth date of deceased (mo., day, yr.) **27 April 1885** 6.(c) If alive, give age **years**

8. AGE: Years **59** Months **9** Days **27** If less than one day
hrs. **.....** min. **.....**

9. Birthplace **Riviere du Loup, P.Q. Canada**
(Town, county, and state)

10. Usual occupation **Bookkeeper**

11. Industry or business

FATHER 12. Name **Arthur Picard**

MOTHER 13. Birthplace **Canada**

14. Maiden name **Elsien M. Grenier**

15. Birthplace **Canada**

16. Informant **Major, C. M. Peters, M.C. US Army**

Address **1608 No. Springwood Drive Silver Spr**

17. Removal **Md**
(Burial, cremation, or removal. Which?) Date thereof. (month) (day) (year)

Cemetery or crematory **Mt. Walliston**

Location **Quincy, Norfolk Co. Mass**

18. Funeral director **Warren & Humphrey**

Address **8434 Ga. Ave. Silver Spring, Md**

19. **Jet 25 1945** **Joyce M. Schaeffer**
(Date rec'd by registrar) **Registrar**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Mass** County **Norfolk**

City or town **Quincy**
(If outside city or town limits, write RURAL and give nearest town)

Street No. **94 Upland Road**

(If rural, give LOCATION)

2.(a) Is veteran, name war **no**

3. (b) Social Security Number
unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH **24 February 1945** at **3:00 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **October 24 1944**, to **24 Feb 1945** and that I last saw her alive on **24 February 1945**.

Immediate cause of death
Peripheral vascular collapse

Due to **Carcinomatosis**
primary site probably pelvis
months

Due to **Hypernephroma of left kidney**
Duration **one year**

Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations **no**
Date of op. **.....**

Autopsy results **no**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: **no**

Accident, suicide, or homicide... Date of ...

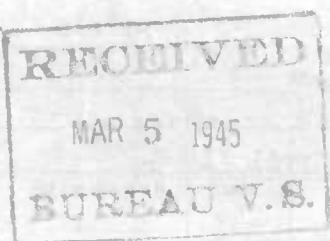
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Casey M. Peters, Maj MC**
M. D. or other

Address **Walter Reed Gen Hospital** signed.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

01913

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery
City or town Dickerson - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter S. Poole Jr.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWSingle

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 27 - 1930 8. (c) If alive, give age years8. AGE: Years 14 Months 0 Days 28 If less than one day hrs. min.9. Birthplace Dickerson, Montg. Md. (Town, county, and state)

10. Usual occupation

Student

11. Industry or business

12. Name Walter S. Poole13. Birthplace Md.14. Maiden name Mabel Hungerford15. Birthplace Md.16. Informant Walter S. PooleAddress Dickerson - Md.17. Burial Date thereof 3 16 45 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MontgomeryLocation Beallsville, Md.18. Funeral director Tom B. HiltonAddress Barnesville, Md.19. Mar. 15 1945 Mrs. C.C. Hilton
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Dickerson (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 - 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Care

and that I last saw him alive on

Immediate cause of death

AsphyxiaDue to Driving (accidental)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 2-25-45

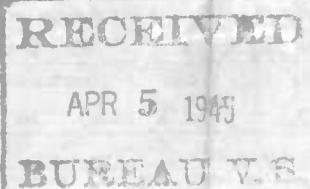
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury drowning Injured at work? No23. SIGNATURE Frank J. Brochard M.D.

Dep. Med. Exam. M. D. or other

Address Gathertown, Md. Date signed 3-15-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01914

Reg. Dist. No.

618

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Hattie L. Prather

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female**col**Single*

6. (b) Name of husband or wife:.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

1895 July 5

8. AGE:

Years

Months

Days

If less than one day

*49**7**22*

hrs.

min.

9. Birthplace:.....

Montgomery Co Md

(Town, county, and state)

10. Usual occupation:.....

Dom

11. Industry or business:.....

Dom

MOTHER FATHER

12. Name:.....

Hattie Prather

13. Birthplace:.....

Montgomery Co Md

14. Maiden name:.....

Martha J. Simpson

15. Birthplace:.....

Montgomery Co Md

16. Informant:.....

Lucy Prather

Address:.....

Gaithersburg Md

17. Burial:.....

Burial

(Burial, cremation, or removal. Which?)

Date thereof:.....

(month) (day) (year)

Cemetery or cemetery:.....

Brookside Cemetery

Location:.....

Taylorsville Md

18. Funeral director:.....

Long W. Barber

Address:.....

Gaithersburg Md

19. (Date rec'd by registrar)

*1945**4**10*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

County.....

Montgomery

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:.....

3. (b) Social Security Number

2

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 27 1945 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Feb 7 1945 to Feb 27 1945*and that I last saw him alive on *Feb 24 1945*Immediate cause of death: *Cardiac arrest and**Pneumonia disease*

DURATION

Due to:.....

Due to:.....

Other conditions:.....

(Include pregnancy within 3 months of death)

Major findings of operations:.....

Date of op.

Autopsy results:.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide:..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

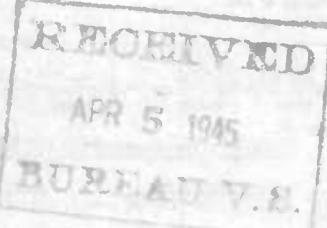
23. SIGNATURE

Vernon H. Dyer M.D.

M. D. or other

Address:.....

*Taylorville Md*Date signed *Febr 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83A

CERTIFICATE OF DEATH

01915

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 hrs

Hospital, institution, or street address where death occurred:

Suburban Hosp.

How long in hospital or institution?

2 hrs

3. (a) FULL NAME

Peter Randall

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

col

married

6. (b) Name of husband or wife

Mattie M. Randall

7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Day

If less than one day

..... hrs. min.

9. Birthplace

DC

(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Government Clerk

MOTHER FATHER

Henry Randall

13. Birthplace

Anne Arundel Co.

14. Maiden name

Isabella Hawkins

15. Birthplace

Anne Arundel Co.

16. Informant

Mattie M. Randall

Address

4435 Hayes St. N.W. Wash. DC

17. Removal

Burial

Cemetery or crematory

Date thereof

(month) (day) (year)

Location

J. B. Johnson

18. Funeral director

467-21-8724

Address

J. B. Johnson

19. 2-36-45-19

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

DC

County

City or town

Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4435 Hayes St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 25

1966, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Evelyn Carr

19

and that I last saw her alive on

19

Immediate cause of death

Cerebral hemorrhage

DURATION

6 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

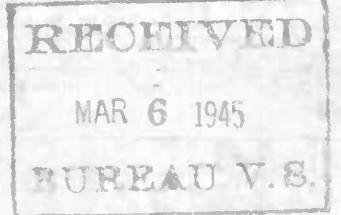
Frank J. Borchard M.D.
Dep. Med. Exam.

M. D. or other

Address

Gaithersburg Md.

Date signed 2-25-66



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

01916

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 hours.....
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 5 hours.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County
City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1404 Yuma Street, N. W.
(If rural, give LOCATION)

3. (a) FULL NAME
Margaret Catherine RAUBER

4. Sex female | 5. Color or race W-US | 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1945 | 8. (c) If alive, give age years

8. AGE: Years | Months | Days | If less than one day five hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER | 12. Name..... Louis J. RAUBER, Comdr. USN
13. Birthplace New York

MOTHER | 14. Maiden name..... Margaret Cranford
15. Birthplace Washington, D. C.

16. Informant Father: Comdr. Lewis J. Rauber
Address 1404 Yuma Street, N. W., Wash., D.C.

17. Burial Date thereof 2-22-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D. C.

18. Funeral director W. W. CHAMBERS RDR
Address 1400 Chapin St., N. W.

19. Feb. 21 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945 at 2:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 1945 to Feb. 21 1945 and that I last saw her alive on Feb. 21 1945

Immediate cause of death..... Pneumonia | DURATION _____

Due to..... Pneumonia | DURATION _____

Due to..... | DURATION _____

Other conditions..... | DURATION _____

(Include pregnancy within 8 months of death)

Major findings or operations..... | Date of op. _____

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of _____

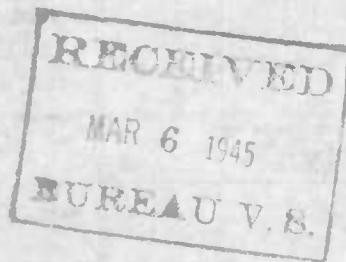
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work? _____

23. SIGNATURE K. J. Otto H. S. OTTO, Comdr. M. D. or other

Address 1404 Yuma Street, N.W. Date signed 2/21/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

01917

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
 City or town Rockville, Md. [114-W. Moultrie]

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.Hospital, institution, or street address where death occurred: Rockville, Md.

How long in hospital or institution?

3. (a) FULL NAME

Rose M. Quark4. Sex Female 5. Color or race W. 6.(a) Single, married, widowed, or divorced widowed8.(b) Name of husband or wife Mayhew7. Birth date of deceased (mo., day, yr.) Oct. 10, 18558. AGE: Years 89 Months 3 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Maryland (Town, county, and state)10. Usual occupation Miller

11. Industry or business

FATHER 12. Name Samuel W. Magruder13. Birthplace Montgomery Co. Md.MOTHER 14. Maiden name Martha Riley15. Birthplace Montgomery Co. Md.16. Informant Miss Disney Magruder, NeiceAddress Rockville, Md.17. Burial Date thereof 2/7/45 (Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Md.18. Funeral director John Pendleton HumphreyAddress 7557 Eds. Ave. Bethesda, Md.19. 2/5 1945 Josephine D. Weston

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville, Md. (If outside city or town limits, write RURAL and give nearest town)Street No. 114-W. Moultrie (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1945 at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Feb. 4, 1945 and that I last saw her alive on Feb. 4, 1945

Immediate cause of death

Cerebral hemorrhageDue to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings or operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE Ethel F. Kuhn M.D. M. D. or otherAddress Rockville, Md. Date signed 2/5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01918

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Chas Scott

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

married

6.(b) Name of husband or wife.....

Annie Scott

7. Birth date of deceased (mo., day, yr.)

5.(c) If alive, give age..... years

May 1870

8. AGE: Years

Months

Days

If less than one day

74 9 hrs. min.

9. Birthplace.....

For county, and state.....

Montgomery Co., Md.

Laborer

10. Usual occupation.....

11. Industry or business.....

Michael Scott

12. Name.....

Howard Co., Md.

13. Birthplace.....

Margaret Howard

14. Maiden name.....

Howard Co., Md.

15. Birthplace.....

Annie Scott (wife)

16. Informant.....

Sandy Spring, Md.

Address.....

Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)

Feb. 10, 1945

(Month) (day) (year)

Cemetery or crematory.....

Sandy Spring, Md.

Location.....

Robert J. S. Gordon

16. Funeral director.....

Address.....

246 n. Wash. St. Rockville

17. Date rec'd by registrar.....

Feb. 10, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6 - 1945 at 9⁴⁵ a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 - 1944 to Feb. 6 - 1945

and that I last saw him alive on Feb. 4 - 1945

Immediate cause of death.....

Chronic Ischaemic Heart
disease with hypertension

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

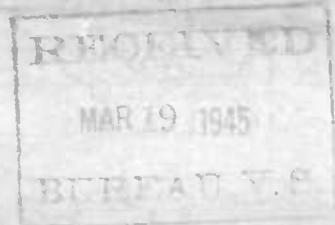
Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other.....

Address..... Sandy Spring, Md. Date signed: Feb. 6, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

01919

CERTIFICATE OF DEATH

Reg. Distr. No. 218

1. PLACE OF DEATH: Montgomery
 County Emory Grove
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Twenty years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MD County Montgomery
 City or town Emory Grove
 Street No. (If outside city or town limits, write RURAL and give nearest town)
 (If rural, give LOCATION) No

3. (a) FULL NAME

Robert H. Sellman4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mannie S. Sellman7. Birth date of deceased (mo. day, yr.) May 25 - 1888 6. (c) If alive, give age 56 years8. AGE: Years 57 Months 8 Days 19 If less than one day hrs. min.9. Birthplace Montgomery Co MD
 (Town, county, and state)10. Usual occupation Labor11. Industry or business Building12. Name Henry Sellman13. Birthplace Montgomery Co MD14. Maiden name Eller Fitzugh15. Birthplace Montgomery Co MD16. Informant Mr. & Mrs. Mannie S. SellmanAddress 201 North Main Street17. Burial Burial Date thereof February 15-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Emory GroveLocation Montgomery Co MD18. Funeral director Bob W. BarberAddress 201 North Main Street19. Date rec'd by registrar Feb 13 1945 Almeda G. Corde

Registrar

3. (b) Social Security Number

218-20-1347

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 - 1945 at 1:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam care to 19 and that I last saw h. alive on 19.

Immediate cause of death

Pulmonary Tuberculosis

Due to

DURATION

18 mo.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

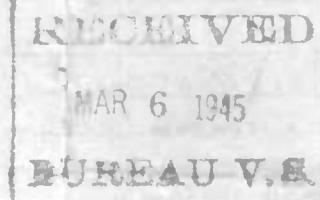
Means of injury Injured at work?

23. SIGNATURE

Frank J. BrockhartDep Med Exam M. D. or otherAddress 201 North Main Street Date signed Feb 13 1945

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED BY THE STATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

01920

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County... *Montgomery*
 City or town... *Poolesville, Maryland*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *40 yrs.*

Hospital, institution, or street address where death occurred:

Poolesville, Maryland

How long in hospital or institution?

3. (a) FULL NAME

John Israel Simms

4. Sex

Male	Colored	Married
------	---------	---------

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Ella G. Simms

7. Birth date of deceased (mo., day, yr.)

*(76) 1868*6.(c) If alive, give age... *69* years

8. AGE:

Years	Months	Days	If less than one day
			hrs. min.
	<i>June</i>		

9. Birthplace

Montgomery
(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

John Israel Simms

FATHER

Montgomery

MOTHER

Maryland

Maiden name

Simms

Birthplace

Montgomery

Informant

Ella G. Simms

Address

Poolesville Md.

Burial

*Burial*Date thereof *Feb 13 46*

(month) (day) (year)

Cemetery or crematory

Montgomery Md.

Location

Near Dickerson

Funeral director

Clarence H. Davis

Address

Poolesville Md.

Date rec'd by registrar

*Feb 13 1945**Frank E. Egli*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Montgomery*City or town... *Poolesville Ind.* (If outside city or town limits, write RURAL and give nearest town)

Street No... (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH *Feb. 10 - 1945*, at *548 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/4 1945 to *2/10 1945*and that I last saw him alive on *2/10 1945*

Immediate cause of death

Septic Pneumonia

DURATION

6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

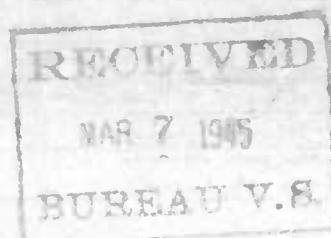
B. D. White, M.D.

M. D. or other

Address... *Poolesville Md.* Date signed *2/10/45*

STAMPS TO TESTIMONY STATE OF AGRICULTURE

1948 30 APRIL 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01921

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery Co.

City or town... Bethesda - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital
10 minutes

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...

City or town... Wash. D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 64 Bryant St NW
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Henry Conroy Sisson (Herbert)

4. Sex

Male white married

6.(a) Single, married, widowed, or divorced

Male white married

6.(b) Name of husband or wife

(Mrs.) Viola Sisson

7. Birth date of deceased (mo., day, yr.)

May 29-1876

6.(c) If alive, give age years

8. AGE:

Years | Months | Days | If less than one day
68 | 8 | 20 | hrs. min.

9. Birthplace

Westmoreland Co - Md.
(Town, county, and state)

10. Usual occupation

meat cutter

11. Industry or business

George S. Sissons

MOTHER FATHER

Name... George S. Sissons

13. Birthplace Virginia

14. Maiden name? Clabbe

15. Birthplace Virginia

16. Informant Mrs. Viola Sisson - wife

Address 64 Bryant St. N.W. Wash. D.C.

17. Removal Date thereof (month) (day) (year)

Cemetery or crematory

Location

The S. N. Jones Co

18. Funeral director

Address 2901-14 st nw

2119 19 45 Wm E Johnson

Registrar

VS A15

19. Date rec'd by registrar

20. MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 18 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

died mid brain case 19 to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Cerebral hemorrhage

Due to

Lobar pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

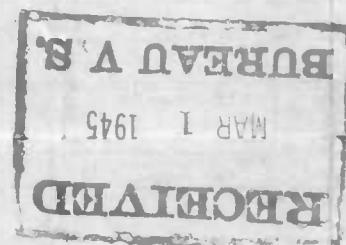
Means of injury Injured at work?

Frank J. Bronchart M.D.

D.P. Med. Exam. M.D. or other

Address

Washington, D.C. Date signed 2-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01922

50+

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Charlotte Sloane

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white.

Single.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 4, 1900

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

11 less than one day

44

6

3

hrs.

min.

9. Birthplace

Roanoke, Virginia

(Town, county, and state)

10. Usual occupation

Nurses Aide

11. Industry or business

Fletcher Sloane

12. Name

Fletcher Sloane

Virginia

13. Birthplace

Cherry Hale

Virginia

14. Maiden name

Cherry Hale

Virginia

15. Birthplace

Harrisonburg, Virginia

Virginia

16. Information

Hospital records

Address

Burl

Date thereof 2/12/45

(month) (day) (year)

Burial, cremation, or removal. Which?

Bucksville Cemetery

Cemetery or crematory

Md

Location

Wm Reuben Paupkurst

18. Funeral director

7557 Wisconsin Avenue

Bethesda, Md

Address

VS A15 T

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No. Due (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1944 to Feb. 7 1945.

and that I last saw her alive on Feb. 7 1945.

Immediate cause of death

Carcinoma of the abdominal organs

Due to the abdominal organs

X-ray following

Due to Carcinoma of breast

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

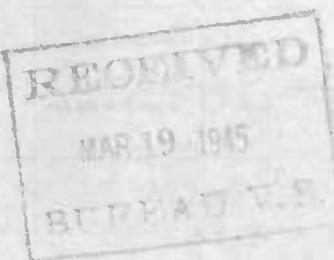
Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE M. D. *Charles J. McLean*Address *Loudy Spring Rd* Date signed *2-8-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01923

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9405 Saybrook Ave.

How long in hospital or institution?

3. (a) FULL NAME

Frederick Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white widowed

6. (b) Name of husband or wife

Eloie Wmifred FosterSmith

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1868

8. AGE:

Years	Months	Days	If less than one day
76	1	10	hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Retired Employee of the

11. Industry or business

Finance Dept of New York City

12. Name

Rev. Elijah F. Smith

MOTHER FATHER

13. Birthplace

England

MOTHER

14. Maiden name

Josephine Foster

FATHER

15. Birthplace

England

16. Informant

Frank Foster Smith

Address 9405 Saybrook Ave, S.S. Md.

17. Transportation + Burial hereof

(Burial, cremation, or removal. Which?) Felt. T. 1945

Cemetery or cemetery

Willimantic Cemetery

Location

Willimantic, Windham Co, Conn.

18. Funeral director

Maxine E. PumphreyAddress Silver Spring, Md.

19. Date rec'd by registrar

Feb. 7th 1945Josephine M. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Connecticut County WindhamCity or town Willimantic (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 6 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jeff Med Exam Case

and that I last saw h. alive on

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

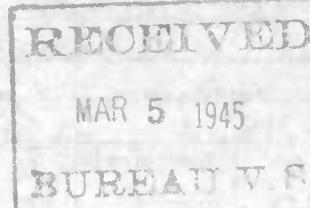
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Borchard M.D.Jeff Med Exam M. D. or otherAddress Glastonbury Rd. Date signed 2-6-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *460*

01924

CERTIFICATE OF DEATH

Reg. Dist. No. *123*

1. PLACE OF DEATH:

County.....

MONTGOMERY

City or town.....

TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *27 yrs.*

Hospital, institution, or street address where death occurred:

10 JEFFERSON AVE.

How long in hospital or institution?.....

3. (a) FULL NAME

SARAH SMITH

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

*WIDOWED.*8. (b) Name of husband or wife *FREDERICK WM. C. SMITH*

8. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) *JAN. 11, 1871*8. AGE: Years *74* Months *1* Days *7* If less than one day hrs. min.9. Birthplace *SOUTH WALES, ENGLAND.*
(Town, county, and state)10. Usual occupation *HOUSEWIFE**OWN HOME.*

11. Industry or business

12. Name *GEORGE TUCKWELL*13. Birthplace *ENGLAND.*14. Maiden name *CAROLINE GOODE.*15. Birthplace *ENGLAND.*16. Informant *MRS. FRED TAYLOR*

Address

113 SHERMAN AVE. TAKOMA PARK, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *FEB. 21, 1945.*

(month) (day) (year)

Cemetery or crematory *CEDAR HILL CEMETERY*Location *PENNSYLVANIA AVE SE*18. Funeral director *J. Arthur Hollings*

Address

*254 Carroll St. N.W. Washington D.C.*19. *Feb. 18th*

(Date rec'd by registrar)

19. *45**J. Arthur Hollings*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

No.

County.....

MONTGOMERY

City or town.....

TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

10 JEFFERSON AVE.

(If rural, give LOCATION)

2.(a) If veteran, same war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

FEBRUARY 18, 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Feb. 5, 1945, to Feb. 18, 1945.*end that I last saw her alive on *Feb. 17, 1945.*

Immediate cause of death.....

Carcinoma - stomach.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

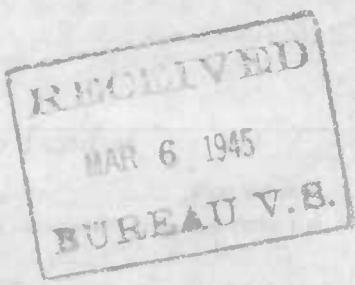
23. SIGNATURE

J.N. Bullock, M.D.

M. D. or other

Address

*766 Rock Ch. Rd.*Date signed *Feb. 18*



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13A

1925

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MarylandCity or town Ricksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 39 years

Hospital, Institution, or street address where death occurred:

400 - West Monty Ave

How long in hospital or institution?

3. (a) FULL NAME

Oda Ruth Thompson

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

John Arthur Thompson

7. Birth date of deceased (mo., day, yr.)

August 8 - 1868

8. (c) If alive, give age years

8. AGE:

Years 76 Months 6 Days 20 If less than one day hrs. min.

9. Birthplace

Hillsboro - Virginia

(Town, county, and state)

10. Usual occupation

At home wife

11. Industry or business

Thomas R. Glendinning

FATHER

12. Name Thomas R. Glendinning

13. Birthplace

Hillsboro - Virginia

MOTHER

14. Maiden name Sarah Jane Hartfield

15. Birthplace

Battleborn, Va.

16. Informant

Mr. Hughel R. Thompson

Address

400 - W-Monty Ave Rockville

17. Burial

Date thereof Mar 21 1945

(Burial, cremation, or removal. Which?)

Cemetery or crematory Hillsboro Church

Location

Hillsboro - Loudon Co - Va

18. Funeral director

Wm. Peabody & Son Lucy

Address

Rockville - Maryland

19. Date rec'd by registrar

2/28/45 Josephine D. Hallen

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

400 - West Monty Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 28 1945 at 5-55 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19... to ... 19...

and that I last saw her alive on Feb 26 1945Immediate cause of death Chronic nephritisDue to SenilityDue to SenilityOther conditions Senile

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

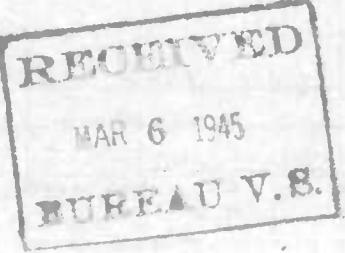
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

C. E. Newell M. D. or other

Address Rockville Md Date signed 2/28/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9B

01926

Reg. Dist. No.

CERTIFICATE OF DEATH

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

MONTGOMERY COUNTY

County CHEVY CHASE, MARYLAND

City or town (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 21 EAST MELROSE STREET, CHEVY CHASE

Stay in hospital or Inst. (yrs., or mos., or days) 20 Years

Stay in this community (yrs., or mos., or days) 20 Years

3. (a) FULL NAME

MRS. EUGENIA TINSLEY

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6 (b) Name of husband or wife George A. Tinsley

7. Birth date of deceased (mo., day, yr.) August 25th, 1855

8. AGE: Years Months Days If less than one day
89 hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER 12. Name Gabriel F. Miller

13. Birthplace Virginia

14. Maiden name Willie Howlett

15. Birthplace Virginia

16. Informant Mrs. Leslie C. Garnett

Address 21 East Melrose Street, Chevy Chase

17. Removal Date thereof 2/5/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mathews, Virginia

Location Mathews, Virginia

18. Funeral director Martin W. Kysong Co.
Address 1300 N. Street, N.W.-Wash. D.C.19. Feb 5 1945
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase, Maryland

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 21 East Melrose Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH February 5th, 1945

19 45 , a.m.

5;15

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 11 1945 to Feb 5 1945 and that I last saw her alive on Feb 3 1945

19 45

5;15

Immediate cause of death

Congestive heart failure

DURATION

3 days

Due to Mental degeneration

6 years

Due to

Other conditions Center City

25 days

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Df autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, Industry, public place (where?)

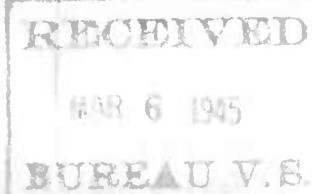
Means of Injury

Injured at work?

23. SIGNATURE

Signature: William C. Drymon
M. D. or other: _____
Address: 1514 - 30th Street, N.W.
Date signed: Feb 5, 1945

8012 - 804
Georgetown



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1242

01927

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Medical, institution, or street address where death occurred:
214 Carroll Ave.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery
City or town..... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Carroll Ave.
(If rural, give LOCATION)
none

2.(a) Is veteran, name war.....

3. (a) FULL NAME

ELIZA E. TURNER

3. (b) Social Security Number
none

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced widowed
------------------	---------------------------	---

B.(b) Name of husband or wife..... Frank S.

6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Sept. 17th. 1877

8. AGE: Years
67 Months
5 Days
5 It less than one day
hrs. min.

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business

FATHER
12. Name..... Levin Clark
13. Birthplace..... Maryland

MOTHER
14. Maiden name..... Frances Barnes
15. Birthplace..... Maryland

16. Informant..... Frank L. Turner

Address 407 Granville Drive, Sil. Spg.

17. Burial Date thereof Feb. 26th. '45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or Removal Place..... Grace Episcopal Church

Location..... Silver Spring, Md.

18. Funeral director..... Wayne & Remphrey.

Address 8434 Ga. Ave. Silver Spring, Md.

19. Date rec'd by registrar..... 1945
(Date rec'd by registrar) *J. H. Dudley* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2/22/45 19..... et 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1959 to Feb. 22 1945

and that I last saw her alive on February 22 1945

Immediate cause of death..... Heart Nellish

Causes leading to death.....
Cerebral hemorrhage
Splenomegaly

Owing to.....

Owing to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

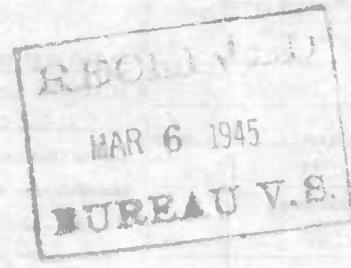
Means of Injury.....

Injured at work?

23. SIGNATURE..... *W.B. Wardrop M.D.*

M. D. or other

Address..... 943 Bonfond St. Date signed..... 2/22/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

01928

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County.....

City or town.....Takoma Park.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Elizabeth Turner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

September 1st 1867

8. AGE:

Years
78

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Fairfax Co. Va.

(Town, county, and state)

10. Usual occupation.....

House keeper.

11. Industry or business

12. Name.....

Mary Johnson.

13. Birthplace

Md.

14. Maiden name.....

Marie Weldon.

15. Birthplace

Potowmack Co., Md.

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....Feb 21 1940
(month) (day) (year)

Cemetery or crematory.....

Fairfax Union Cemetery

Location.....

Fairfax Union, Maryland

18. Funeral director.....

Rabert L. Spangler

Address.....

246 N. Wash. St. Rockville

19. Date rec'd by registrar

19. 40

19. 40

Josephine M. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....Montgomery

City or town.....

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) II veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb. 17, 1940

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 13, 1940 to Feb. 17, 1940and that I last saw him alive on Feb. 17, 1940.

Immediate cause of death.....

Congestive heart failure

DURATION

24 hrs

Due to.....SARS pneumonia

5 days

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

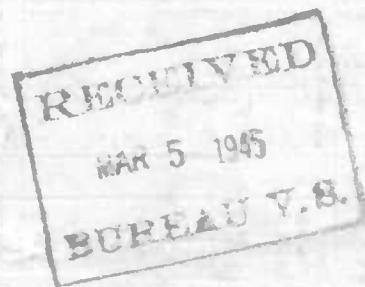
Injured at work?

23. SIGNATURE.....

J. Shettie M.D.

M. D. or other

Address.....6911 8th St. NWDate signed Feb. 17, 1940



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

01929

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 59 days

3. (a) FULL NAME

Ella Umpstead

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo. day yr.)

6.(c) If alive, give age

years

August 22, 1868

8. AGE:

Years

Months

Days

If less than one day

76

5

29

hrs.

min.

9. Birthplace Bayard, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Richard Umpstead

13. Birthplace Bayard, Maryland

14. Maiden name Frances Austin

15. Birthplace Bayard, Maryland

16. Informant

Address

17. Burial Date thereof Feb. 28, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville Md.

18. Funeral director Mr. B. Kilton

Address Barnesville, Md.

19. 2-26-1948 218 Gates
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Poolesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26.

19 45 at 7²⁰/a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 26, 1945 19..... to 19.....

and that I last saw her alive on 19.....

Immediate cause of death Diabetes mellitus

DURATION

Due to

Due to

Other conditions Atherosclerosis

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

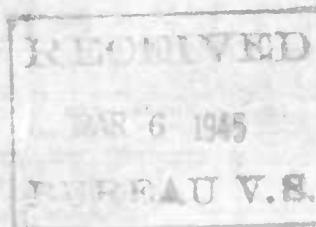
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Suburban Hospital Date signed 2-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7-1-c

01930

CERTIFICATE OF DEATH

Reg. Distr. No. 217

1. PLACE OF DEATH

County... Montgomery

City or town... Olney, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montgomery Co. General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Alfred Walker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Col.

married

6. (b) Name of husband or wife

Ida Walker

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

May 10. 1885 -

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Montgomery Co., Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Remus Walker

12. Name

Montgomery Co., Md.

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Ida Walker

Address

Burial

Date thereof Feb 17, 1945
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Sandy Springs

Location

Sandy Springs, Md.

18. Funeral director

Robert St. Andrean

Address

246 N. Wash. St. Rockville

19. 2-15-1945

(Date rec'd by registrar)

Gentleman's Law Co.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Olney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 13 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dey Fred Exam case 19 and that I last saw h. alive on 19

Immediate cause of death

exposure
acute alcoholism

Due to

DURATION

12 hrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschart M.D.
Dey Fred Exam M.D. or other

Olney, Maryland, Md. Date signed 2-13-45

RECEIVED
MAR 19 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

CERTIFICATE OF DEATH

01931

Reg. Dist. No. 212

1. PLACE OF DEATH:

County

Montgomery

City or town

Dickerson - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

David Warfield

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

Sept. 29 - 1928

8. AGE:

Years

Months

Days

If less than one day

16

4

26

hrs. min.

9. Birthplace

Dickerson, Montg. Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

William Warfield

MOTHER FATHER

12. Name

Md.

13. Birthplace

Md.

14. Maiden name

Betty Hardy

15. Birthplace

Md.

16. Informant

Mrs. Wm. Warfield

Address

Dickerson, Md.

17. Burial

Date thereof 3 15 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Monocacy, Md.

Location

Boulderville, Md.

18. Funeral director

Tom B. Hilton

Address

Boulderville, Md.

19. Mar. 15 45

Mrs. C.C. Hilton

(Date rec'd by registrar)

By Mrs. Wm. B. Hilton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Montgomery

City or town

Dickerson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 25

1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def Med Exam care

19

and that I just saw h.....alive on

19

Immediate cause of death

Suffocation (accidental)

Due to: Suffocation

DURATION

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 2-25-45Where did injury occur? Dickerson (City or town) Montgomery (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury

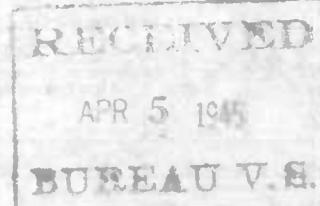
Injured at work?

23. SIGNATURE

Frank J. Brochart M.D.
Def Med Exam. M. D. or otherAddress: Charlottesville, Va. Date signed: 3-15-45

RECEIVED TO TWENTIETH STATE GUARD

RECEIVED BY STATION



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-1

01932

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 daysHospital, Institution, or street address where death occurred: Home - 4520 Ridge St.

How long in hospital or institution?

3. (a) FULL NAME

Marjorie B. Weisbrodt4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married8. (b) Name of husband or wife Paul E.7. Birth date of deceased (mo., day, yr.) Oct. 15, 1922 6. (c) If alive, give age years8. AGE: Years 22 Months 4 Days 27 If less than one day

hrs. _____ min. _____

9. Birthplace Maryland (town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Richard F. Clagett13. Birthplace Md.14. Maiden name Nester Mary O'Neal15. Birthplace Maryland16. Informant Nestor O'NealAddress 4520 Ridge St. Ch. C. L.17. Burial Burial Date thereof 2/12/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockville Cem. Assoc.Location Rockville, Md.18. Funeral director Wm. Ruben PamphreyAddress 7557 Wisconsin Ave. Bethesda, Md.19. 2/12 19. 45 2/15 1945 2/15 1945

(Date rec'd by registrar) (Date of death) (Date of issue) (Date registered)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Bethesda (If outside city or town limits, write RURAL and give nearest town)Street No. 4520 Ridge St. (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 12, 1945 at _____

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 20 1944 to Feb. 12 1945and that I last saw deceased alive on Feb. 11 1945

Immediate cause of death

Pulmonary Tuberculosis DURATION 15 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Thompson, Bealebody M. D. or otherAddress 1746 1st St. N.W. Date signed

RECEIVED

MAR 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01933

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

Montgomery
Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 1/2 hrs

Hospital, institution, or street address where death occurred:

22 E. Bradley Lane

How long in hospital or institution?.....

3. (a) FULL NAME

Elmer B Weston

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male white Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

about

1875-

8. AGE:

Years Months Days If less than one day
about 70 hrs. . . . min.

9. Birthplace.....

Pa

(Town, county, and state)

10. Usual occupation.....

Salesman

11. Industry or business

12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... unknown

16. Informant..... Mr. Hembright

Address 1369 Columbia Rd., N.W.

17. (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)
Cremation

Cemetery or crematory..... Bethesda Pa Cem

Location..... Pennsylvania

18. Funeral director..... Mr. Paul P. Humphrey

Address 7557 Wisconsin Ave. Bethesda, Md.

19. Feb 8 1945 2pm E. Jobes

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C.

County.....

Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.... 3617 13th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 5 1945 18:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death.....

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Frank J. Broschart M.D.

D.P.M. Exam M.D. or other

Address..... 14th Street and Date signed 2-6-45



RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH ENFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10R

01935

CERTIFICATE OF DEATH

Reg. Dlat. No.

216

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery
Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?.....

3. (a) FULL NAME

Archie Williams

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white married

6.(b) Name of husband or wife.....

Madeline

7. Birth date of

deceased (mo., day, yr.)

Nov-11, 1916

6.(c) If alive, give age.....

years

8. AGE:

Years Months Days If less than one day
28 2 28 hrs. min.

9. Birthplace.....

Virginia

(Town, county, and state)

10. Usual occupation.....

Cab driver

11. Industry or business

FATHER

12. Name..... O-K. Williams

13. Birthplace

Virginia

MOTHER

14. Maiden name.....

Ida Brooks

15. Birthplace

Virginia

16. Informant.....

Madeline T. Williams

Address

7731 Georgetown Rd.

Burial

Date thereof..... 2/11/45

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Merry Virginia

Location.....

Virginia

16. Funeral director.....

Tom Gribben Humphrey

Address

7557 Wisconsin Ave. Bethesda

19. (Date rec'd by registrar)

1945 M. E. John Md

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 7731 Georgetown Rd. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 8

1945 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6 1945 to Feb 8 1945

and that I last saw h. i. n. alive on Feb 8 1945

Immediate cause of death.....

Tobacco pneumonia

DURATION

3 days

Due to.....

Due to.....

Other conditions.....

Fatty degeneration of liver

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

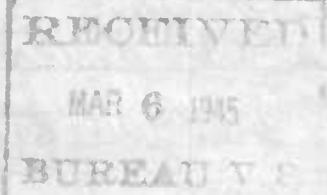
Injured at work?

23. SIGNATURE

Paul Shatto MD

M. D. or other

Address..... 7425 Wisconsin Date signed..... 2/10/45



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

01936

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery
 City or town Beallsville - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Marie Irene Williams

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fem.	<u>white</u>	<u>Married</u>
------	--------------	----------------

6. (b) Name of husband or wife

John A. Williams

7. Birth date of deceased (mo., day, yr.)

Feb. 8 - 19036. (c) If alive, give age 54 years

8. AGE:

Years <u>41</u>	Months <u>11</u>	Days <u>23</u>	If less than one day hrs. <u></u> min. <u></u>
-----------------	------------------	----------------	---

9. Birthplace

Wyo. Smoky Cr. Virginia
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Miller Creager

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Glynnsville (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1945 at 3 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/20 1944, to 2/1 - 1945and that I last saw h. er alive on 2/1 1945

Immediate cause of death

Cerebral HemorrhageDue to arteriosclerosis& hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. J. White, M.D. M. D. or otherAddress Beallsville, Md. Date signed 2/11/4519. 2/2/45 19. (Date rec'd by registrar)Mrs. C. C. Hilton
 Registrar

RECEIVED
MAR 7 1945
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1937

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

9 days

3. (a) FULL NAME

Charles Frederick Wulff

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

B. (b) Name of husband or wife

Susan

7. Birth date of deceased (mo., day, yr.)

Sept-6, 1868

B. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

75 4 27 hrs. min.

9. Birthplace

Sweden
(Town, county, and state)

10. Usual occupation

Helper

11. Industry or business

Carl Wulff

12. Name

Carl Wulff

13. Birthplace

Germany

14. Maiden name

Amelia Anderson

15. Birthplace

Sweden

16. Informant

Mrs. W. H. Garrison (Daughter)

Address

5532 Manning Drive

17. Disposition

Date thereof 2/3/45
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Altona, Pa.

18. Funeral director

Gen. Funeral Furnishers

Address

7557 Wisconsin Ave, Bethesda19. 2-3-4519.....
(Date rec'd by registrar)19.....
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 5532 Manning Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb-29 1945 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-8-45 19 to 2/2/45 19and that I last saw h. m. alive on 2/1/45 19

Immediate cause of death

Cerebral Thrombosis

DURATION

3 wks.

Due to

Advanced Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul D'Antonio MD

M. D. or other

Address 7425 Wisconsin Ave Date signed 2/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

1938

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County *Maryland*
 City or town *Gardensburg Md* A. F. J.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 1/2 yrs*
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Helen E Wood

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female	white	widow
--------	-------	-------

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 16 1898

8. AGE:

Years

Months

Days

If less than one day

46	7	8	hrs.	min.
----	---	---	------	------

9. Birthplace

Washington DC

(Town, county, and state)

10. Usual occupation

housework

11. Industry or business

MOTHER FATHER

12. Name

Edward Johnson

13. Birthplace

Ward DC

14. Maiden name

Johnson

15. Birthplace

16. Informant

Lorraine F Ege

Address

Gardensburg Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Massachusetts Cem.

Location

Woodstock VA

18. Funeral director

Hellinger & Son

Address

Woodstock VA

19. Date rec'd by registrar

Feb 21 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Maryland*City or town *Gardensburg MD*
 (If outside city or town limits, write RURAL and give nearest town)Street No. *Shady Grove Rd*
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 21* 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dep. med. Ex-19 to *19*and that I last saw h. alive on *19*

Immediate cause of death

*Barbituric acid
hangover (suicide)*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Suicide* Date of *2-21-45*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brochart M.D.

Dep. Med. Ex-19 M. D. or other

Address *Gardensburg MD* Date signed *2-21-45*



M
PLEASE WRITE PLAINLY, WITH UNFADING INK
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *26*

CERTIFICATE OF DEATH

"1939

Reg. Dist. No. 26

1. PLACE OF DEATH:

County *Montgomery*City or town *Bethesda* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

*Sibley Hospital*How long in hospital or institution? *5 hours*

3. (a) FULL NAME

*Marie Wood*4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Norman*7. Birth date of deceased (mo., day, yr.) *May 30, 1880* 8. (c) If alive, give age *years*8. AGE: Years *64* Months *9* Days *25* If less than one day *hrs.* *min.*9. Birthplace *New York* (Town, county, and state)10. Usual occupation *Housewife*

11. Industry or business

12. Name *James Robey*13. Birthplace *Macomb, Ill.*14. Maiden name *Catherine O'Donahue*15. Birthplace *Rochester, N.Y.*16. Informant *Mrs. Carter*Address *4712 River Rd. n.w. Wash. D.C.*17. *Shipment* Date thereof *2/26/45* (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory *Staton Island, N.Y.*Location *Staton Island, N.Y.*18. Funeral director *Geo. Deulen & Son*Address *7557 Wisconsin Ave. Bethesda*19. *2/26 1945* Inj. *2nd* (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *New York* County *Staten Island*City or town *Staten Island* (If outside city or town limits, write RURAL and give nearest town)Street No. *482 Board Ave.* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 24, 1945* at *6:20 p.m.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *2/24* to *1945*, *2/24* to *1945*and that I last saw her *alive* on *2/24* *1945*

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. Keith Cromer M. D. or otherAddress *U.S. Naval Disp. Wash. D.C.* Date signed *2/25/45*

